STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street
San Francisco, California 94105

NOTICE OF PROPOSED EMERGENCY ACTION PURSUANT TO INSURANCE CODE SECTION 10133.5 AND GOVERNMENT CODE SECTION 11346.1

Date: January 12, 2015 **REGULATION FILE:** ER-2015-00001

PROVIDER NETWORK ADEQUACY EMERGENCY REGULATION

Title 10. Investment
Chapter 5. Insurance Commissioner
Subchapter 2. Policy Forms and Other Documents
Article 6. Provider Network Access Standards for Disability Policies and Agreements

Amend § 2240. Definitions.
As used in this Article:
~~(a) "Basic health care services" means any of the following covered health care services provided for in the applicable insurance contract or certificate of coverage:~~
~~(1) Physician services, including consultation and referral.~~
~~(2) Hospital inpatient services and ambulatory care services.~~
~~(3) Diagnostic laboratory diagnostic and therapeutic radiologic services.~~
~~(4) Home health services.~~
~~(5) Preventive health services.~~
~~(6) Emergency health care services, including ambulance services.~~
~~(7) Mental health care services including those intended to meet the requirements of Insurance Code 10144.5.~~
~~(8) Any other health care or supportive services that are covered pursuant to an insurance contract.~~
(~~b~~ a) "Certificate" means an individual or family certificate of coverage issued pursuant to a insurance contract.
(~~c~~ b) "Covered person" means either a primary covered person or a dependent covered person eligible to receive ~~basic~~ health care services under the insurance contract providing network provider services.

(~~d~~ c) "Dependent covered person" means someone who is eligible for coverage under an insurance contract through his or her relationship with or dependency upon a primary covered person.
(~~e~~ d) "Emergency health care services" means health care services rendered for any condition ~~in which the covered person is in danger of loss of life or serious injury or illness or is experiencing severe pain and suffering.~~ manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy, (2) Serious impairment to bodily functions, (3) Serious dysfunction of any bodily organ or part, (4) active labor. "Emergency health care services" also includes services rendered for a psychiatric emergency.
(e) "Essential community provider" (ECP) means providers that serve predominantly low-income, medically underserved individuals, as defined in 45 CFR Section 156.235 , published May 27, 2012, subdivision (c) of which is incorporated herein by this reference.
(f) "Network provider" means an institution or a health care professional which renders health care services to covered persons pursuant to a contract to provide such services at alternative rates.
(g) "Network provider services" means health care services which are covered under an insurance contract when rendered by a network provider within the service area.
(h) "Non-network provider services" means covered health care services delivered by a health care provider who is not contracted with the insurer either directly or indirectly.
(i) "Health care professional" means a licensee or certificate holder enumerated in Insurance Code 10176 as of the effective date of this Article or as that Section may be amended thereafter.
(j) "Insurer" means an insurer who provides "health insurance" as defined in Section 106(b), and includes those who authorize insureds to select providers who have contracted with the insurer for alternative rates of payment as described in Section 10133.
(k) "Primary care physician" means a physician who is responsible for providing initial and primary care to patients, for maintaining the continuity of patient care or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.
(l) "Primary covered person" means a person eligible for coverage under an insurance contract or certificate.
(m) "Service area" means the State of California or any other geographic area within the state designated in the contract within which network provider services are rendered to covered persons for covered benefits.
(n) "Network" means all institutions or health care professionals that are utilized to provide medical services to covered persons pursuant to a contract with an insurer to provide such services at alternative rates as described in Insurance Code Section 10133. A network as defined herein can be directly contracted with by an insurer or leased by an insurer.
(o) "Limited English proficiency" means a limited ability, or an inability, to speak, read, write, or understand the English language at a level that permits the covered person to interact effectively with his or her health care providers or health insurer.
Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 106(b), 10133, 10133.5, 10144.5 and 10176, Insurance Code.

Amend§ 2240.1. Adequacy and Accessibility of Provider Services.
(a) The provisions of this article apply to "health insurance" policies as defined by Insurance Code section 106(b). Notwithstanding the above, the provisions of this article do not apply to ~~supplemental~~ specialized policies of health insurance that provide coverage for vision care expenses only or dental care expenses only, except that the provisions of this article as specified in section 2240.16 apply to any policy covering the pediatric vision and/or oral essential health benefit described in Insurance Code section 10112.27.
(b) In arranging for network provider services, insurers shall ensure that:
(1) Network providers are duly licensed or accredited and that they are sufficient, in number ~~or size~~, capacity, and specialty, to be capable of furnishing the health care services covered by the insurance contract, taking into account the number of covered persons, their characteristics and medical needs including the frequency of accessing needed medical care within the prescribed geographic distances outlined herein and the projected demand for services by type of services.
(2) Decisions pertaining to health care services to be rendered by providers to covered persons are based on such persons' medical needs and are made by or under the supervision of licensed and appropriate health care professionals.
(3) Facilities used by providers to render basic health care services are located within reasonable proximity to the work places or the principal residences of the primary covered persons, are reasonably accessible by public transportation and are reasonably accessible to the physically handicapped.
(4) ~~Basic h~~Health care services (excluding emergency health care services) are available at least 40 hours per week, except for weeks including holidays. Such services shall be available until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday, except for Saturdays falling on holidays.
(5) Emergency health care services are available and accessible within the service area at all times.
(6) ~~Basic h~~Health care services are accessible to covered persons through network providers, or other network arrangement.
(7) Network provider services are rendered pursuant to written procedures which include a documented system for monitoring and evaluating accessibility of such care. The monitoring of waiting time for appointments, as described in Section 2240.15, shall be a part of such a system.
(c) In arranging for network provider services, insurers shall ensure that:
(1) There is the equivalent of at least one full-time physician per 1,200 covered persons and at least the equivalent of one full-time primary care physician per 2,000 covered persons.
(2) There are primary care network providers with sufficient capacity to accept covered persons within 30 minutes or 15 miles of each covered person's residence or workplace.
(3) There are adequate full-time equivalents of primary care physicians in the network accepting new patients covered by the policy to accommodate anticipated enrollment growth.
(~~3~~ 4) There are medically required network specialists who are certified or eligible for certification by the appropriate specialty board with sufficient capacity to accept covered persons within 60 minutes or 30 miles of a covered person's residence or workplace. Notwithstanding the above, the Commissioner may determine that certain medical needs require network specialty care located closer to covered persons when the nature and frequency of use of such health care services, and the standards of Insurance Code 10133.5(b) (3), support such modification.

(45) There are mental health and substance use disorder professionals with skills appropriate to care for the mental health and substance use disorder needs of covered persons and with sufficient capacity to accept covered persons within 30 minutes or 15 miles of a covered person's residence or workplace. The network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy. The network must take into account the pattern and frequency with which different therapies, particularly behavioral health therapy, are provided for different patient populations at different ages, such that if it is clinically necessary for a network to have services available in closer proximity to affected covered persons than required by the minimum time and proximity standards stated above then the insurer shall make the services available in such closer proximity.

(A) Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, detoxification, outpatient mental health and substance abuse evaluation and treatment, psychological testing, outpatient services for monitoring drug therapy, partial hospitalization, intensive outpatient treatment, short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour monitoring by clinical staff for stabilization of an acute psychiatric crisis, psychiatric observation for an acute psychiatric crisis and services from mental health providers. Networks must also provide for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, including residential care. There must be mental health and substance abuse disorder providers of sufficient number and type to provide diagnosis and medically necessary treatment through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat mental health and substance abuse disorders.

(B) An insurer must establish a reasonable standard approved by the Department for the number and geographic distribution of mental health providers who can treat severe mental illness of an adult and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure, and those practitioners described in subdivision (c) of section 10144.51 of the Insurance Code.

(C) The insurer must submit a narrative report describing the adequacy of its mental health and substance abuse disorder network to the Department for approval no less frequently than annually as part of the network adequacy report required by Section 2240.5.

(D) An insurer must include a sufficient number of the appropriate types of mental health and substance use disorder treatment providers and facilities based on normal utilization patterns.

(E) An insurer must ensure that covered persons can access information about mental health and substance use disorder services, including benefits, providers, coverage, and other relevant information, by calling a customer service representative during normal business hours.

(5 6) There is a network hospital with sufficient capacity to accept covered persons for covered services within 30 minutes or 15 miles of a covered person's residence or workplace. Networks must include hospitals with sufficient capacity to serve the entire population of covered persons based on normal utilization patterns.

(7) The network includes adequate numbers of available primary care providers and specialists with admitting and practice privileges at network hospitals.

(8) The network includes an adequate number of network outpatient retail pharmacies located in sufficient proximity to covered persons to permit adequate routine and emergency access. Similarly, ancillary laboratory and other services dispensed by order or prescription of the

primary care provider are available from contracting providers at locations (where covered persons are personally served) within a reasonable distance from the primary care provider.
(d) Networks shall be designed to optimize access by using a variety of facility types, such as ambulatory surgical centers. Further, access to facilities, such as dialysis centers, shall be designed to accommodate the intensity and frequency of use by the patient population, so as to minimize the impact of accessing the service on the patient's work and life activities.
(e) Networks must provide access to medically appropriate care from a qualified provider. If medically appropriate care cannot be provided within the network, the insurer shall arrange for the required care with available and accessible providers outside the network, with the patient responsible for paying only the in-network cost sharing for the service. In addition to in-network copayments and coinsurance, in-network cost sharing includes applicability of the in-network deductible and accrual of cost sharing to the in-network out-of-pocket maximum.
(f) An adequate network must also demonstrate the capacity to provide medically necessary organ, tissue, and stem cell transplant surgery. The insurer in its network adequacy report required by Section 22240.5 shall identify and locate each transplant center in its network by name and address, and type of transplant provided in the facility.
(g) Health carrier standards for the selection and tiering of participating providers and facilities shall be developed for primary care professionals and each health care professional specialty and facility, shall include measures related to standards for quality of care and health outcomes, and shall be provided to the Department no less frequently than annually as part of the network adequacy report required by Section 2240.5. The standards shall be used in determining the selection of health care professionals and facilities by the health carrier, its intermediaries and any provider networks with which it contracts. Selection criteria shall not be established in a manner:
(1) That would allow a health carrier to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization; or
(2) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization.
(h) An insurer shall include a sufficient number and geographic distribution of essential community providers in its networks for products sold through the California Health Benefit Exchange.
(i) Networks for mountainous rural areas shall take into consideration typical patterns of winter road closures, so as to comply with access and timeliness standards throughout the calendar year.
(j) The insurer must measure the adequacy of its network at least twice a year, and demonstrate and attest to the Department that it has done so, and submit a corrective action plan to the Commissioner if the standards set forth in this article are not met.
(k) Notwithstanding the above, the Commissioner may determine that certain medical needs require network providers and/or facilities located closer to covered persons when the nature and frequency of use of such health care services, and the standards of Insurance Code section 10133.5(b) (3), support such modification.
(~~6~~ *l*) Notwithstanding the above, these requirements are not intended to prevent the covered person from selecting providers as allowed by their insurance contract beyond the applicable geographic area specified by these standards.
~~(7) If an insurer is unable to meet the network access standard(s) required by this section due to the absence of practicing providers located within sufficient geographic proximity of the~~

~~insurer's covered persons, the insurer may apply to the Commissioner for a discretionary waiver of any network access standard for the applicable geographic area. Such application should include, at a minimum, a description of the affected area and covered persons in that area and how the insurer determined the absence of practicing providers~~.
(~~d~~ m) In determining whether an insurer's arrangements for network provider services comply with these regulations, the Commissioner shall consider to the extent the Commission deems necessary, the practices of comparable health care service plans licensed under the Knox-Keene Health Care Service Plan Act of 1975 Health and Safety Code Section 1340, et seq.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133 and 10133.5, Insurance Code.

Adopt new § 2240.15. Network Access Appointment Waiting Time Standards; Quality Assurance; Disclosure and Education.
(a) For purposes of this section, the following definitions apply:
(1) "Appointment waiting time" means the time from the initial request for health care services by a covered person or the covered person's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the insurer or completing any other condition or requirement of the insurer or its contracting providers.
(2) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of an insurer includes but is not limited to all of the services required by Insurance Code section 10112.2 (incorporating the requirements of 45 United States Code § 300gg–13 (Public Health Service Ace §2713), and 45 Code of Federal Regulations § 146.130) and subdivision (a)(2)(A)(ii) of section 10112.27 of the Insurance Code.
(3) "Provider group" has the meaning set forth in subdivision (g)(3) of section 10133.56 of the Insurance Code.
(4) "Triage" or "screening" means the assessment of a covered person's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an insured who may need care, for the purpose of determining the urgency of the covered person's need for care.
(5) "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an insured who may need care.
(6) "Urgent care" means health care for a condition that requires prompt attention, consistent with subdivision (h)(2) of section 10123.135 of the Insurance Code.
(b) Standards for Timely Access to Care.
(1) Insurers shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the covered person's condition consistent with good professional practice. Insurers shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.
(2) Insurers shall ensure that all network and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to covered persons in a timely

manner appropriate for the covered person's condition and in compliance with the requirements of this section.
(3) When it is necessary for a provider or a covered person to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the covered person's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 10133.5 of the Insurance Code and the requirements of this section.
(4) Interpreter services required by Section 10133.8 of the Insurance Code and Article 12 of Title 10 California Code of Regulations, commencing with Section 2538.1, shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment consistent with Title 10, California Code of Regulations, section 2538.6 without imposing an undue delay on the scheduling of the appointment. This subdivision (c)(4) does not modify the requirements established in sections 10133.8 or 10133.9 of the Insurance Code.
(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subdivision (c)(1), each insurer shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer covered persons appointments that meet the following timeframes:
(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in subdivision (b)(5)(G);
(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subdivision (b)(5)(G);
(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in subdivisions (b)(5)(G) and (b)(5)(H);
(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in subdivisions (b)(5)(G) and (b)(5)(H);
(E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in subdivisions (b)(5)(G) and (b)(5)(H);
(F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in subdivisions (b)(5)(G) and (b)(5)(H);
(G) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the covered person;
(H) Preventive care services, as defined at subdivision (a)(2), and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice; and
(6) Insurers shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section. This section does not modify the requirements regarding provider adequacy and accessibility established by this Article.

(7) Insurers shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined in subdivision (a)(5).
(A) Insurers shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the insured's condition, and that the triage or screening waiting time does not exceed 30 minutes.
(B) An insurer may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: insurer-operated telephone triage or screening services consistent with subdivision (b)(5); telephone medical advice services pursuant to Section 10279 of the Insurance Code; the insurer's contracted primary care and mental health care provider network; or other method that provides triage or screening services consistent with the requirements of this subdivision (b)(7)(B).
(8) An insurer that arranges for the provision of telephone triage or screening services through contracted primary care and mental health care providers shall require those providers to maintain a procedure for triaging or screening covered persons' telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, that will inform the caller:
(A) Regarding the length of wait for a return call from the provider; and
(B) How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.
(9) An insurer that arranges for the provision of triage or screening services through contracted primary care and mental health care providers who are unable to meet the time-elapsed standards established in paragraph (b)(7)(A) shall also provide or arrange for the provision of insurer-contracted or operated triage or screening services, which shall, at a minimum, be made available to covered persons affected by that portion of the insurer's network.
(10) Unlicensed staff persons handling covered person calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of a covered person so that the covered person can be referred to licensed staff. However, under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of a covered person or determine when a covered person needs to be seen by a licensed medical professional.
(11) Insurers shall ensure that, during normal business hours, the waiting time for a covered person to speak by telephone with an insurer customer service representative knowledgeable and competent regarding the covered person's questions and concerns shall not exceed ten (10) minutes, or that the covered person will receive a scheduled call-back within 30 minutes.
(c) Quality Assurance Processes. Each insurer shall have written quality assurance systems, policies and procedures designed to ensure that the insurer's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Insurance Code and this section. An insurer's quality assurance program shall address:
(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.
(2) Compliance monitoring policies and procedures, filed for the Commissioner's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:
(A) Tracking and documenting network capacity and availability with respect to the standards set forth in subdivision (b);

(B) Conducting an annual covered person experience survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to ascertain compliance with the standards set forth in subdivision (b). The Department will make this survey publicly available; and
(C) Conducting an annual provider survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to solicit, from physicians and non-physician mental health providers, perspective and concerns regarding compliance with the standards set forth at subdivision (b). The Department will make this survey publicly available; and
(D) Reviewing and evaluating, no less frequently than quarterly, the information available to the insurer regarding accessibility, availability and continuity of care, including but not limited to information obtained through covered person and provider surveys, covered person grievances and appeals, and triage or screening services.
(3) An insurer shall implement prompt investigation and corrective action when compliance monitoring discloses that the insurer's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Insurers shall give advance written notice to all contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the insurer's corrective action.
(d) Disclosure and Education.
(1) Insurers shall disclose in all policies, certificates, and coverage materials the availability of triage or screening services and how to obtain those services. Insurers shall disclose annually, in insurer newsletters or comparable communications to covered persons, the insurer's standards for timely access.
(2) The telephone number at which covered persons can access triage and screening services shall be included on covered person membership cards. An insurer may comply with this requirement through an additional selection in its automated customer service telephone answering system, where applicable, provided that the customer service number is included on the covered person's membership card.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 106(b), 10133 and 10133.5, Insurance Code.

Adopt new § 2240.16 Access Standards for Pediatric Vision and Oral Essential Health Benefits.
(a) Policies covering the pediatric essential health benefit must assure that there are adequate full-time equivalents of primary care network practitioners accepting new patients covered by the policy to accommodate anticipated enrollment growth.
(b) In addition to ensuring compliance with the clinical appropriateness standard set forth in subdivision (b)(1) of Section 2240.15, each insurance policy covering the pediatric dental and/or vision essential health benefit shall ensure that contracted oral and vision provider networks have adequate capacity and availability of licensed health care providers, including generalist and specialist dentists, ophthalmologists, optometrists, and opticians to offer insureds appointments for covered oral and vision services in accordance with the following requirements:

(1) Urgent appointments within the pediatric oral and vision provider network shall be offered within 72 hours of the time of request for appointment, when consistent with the covered person's individual needs and as required by professionally recognized standards of practice;
(2) Non-urgent appointments shall be offered within 36 business days of the request for appointment; and
(3) Preventive pediatric oral and vision care appointments shall be offered within 40 business days of the request for appointment.
(c) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the covered person;

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 106(b), 10133 and 10133.5, 10112.27 Insurance Code.

Amend § 2240.4. Contracts with ~~Exclusive~~ Network Providers.
(a) Insurers shall establish written policies and procedures for recruiting network providers, credentialing network providers, contracting with network providers, and managing their networks.
~~(a)~~ (b) Effective June 30, 2008, contracts between network providers and insurers or their agents shall: 1) be in writing and be fair and reasonable as to the parties to such contracts; 2) provide that network providers shall not make any additional charges for rendering network services except as provided for in the contract between the insurer and the insured; 3) include all the agreements between the parties pertaining to the rendering of network provider services; 4) recite that the provider's primary consideration shall be the quality of the health care services rendered to covered persons; 5) include provisions ensuring that providers shall not discriminate against any insured in the provision of contracted services on the basis of sex, , marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status health insurance coverage, utilization of medical or mental health services or supplies, or other unlawful basis including without limitation, the filing by such insured of any complaint, grievance, or legal action against a provider; ~~.~~ 6) contain a provision requiring that network facilities shall determine and disclose to the insured person prior to an insured person's non-emergency episode of care the non-network providers who are likely to be involved in providing care, and the estimated cost of that non-network care to the insured person. For example, for a surgery in a network hospital, the hospital shall disclose to the insured person, prior to the surgery, all non-network providers, such as anesthesiologists, radiologists, and pathologists, who are anticipated to be involved in the insured person's care, and the estimated cost of their non-network services. This disclosure is to be made sufficiently in advance of the scheduled episode of care to afford the insured person a reasonable opportunity to explore alternate arrangements.
(c) Insurers shall afford essential community providers equal opportunity to participate in contracts for alternative rates of payment to assure adequacy of number and location of institutional facilities and professional providers in what have been determined to be underserved communities and populations.
(1) An insurer shall not discriminate against a provider on the basis of the provider's qualifying as an essential community provider under state or federal law.

(2) When contracting with an essential community provider, an insurer shall offer contractual terms that are fair and reasonable, and similar to the terms offered to other similarly situated providers.
(3) Nothing in this section shall be construed to require an insurer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of the insurer.
(d) An insurer shall notify the Department within 10 days before the termination of a contract with a provider, provider group, or facility, and in such notice shall demonstrate that its network remains in compliance with the network adequacy requirements of this Article.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133 and 10133.5, Insurance Code.

Amend § 2240.5. Filing and Reporting Requirements.
(a) For all health insurance policies that include the option of utilizing contracted providers to provide health care services, the insurer shall file a network adequacy report with the Department, with accompanying documents, as follows:
(1) Beginning on June 1, 2015 and, notwithstanding any additional filings the insurer may have made, annually thereafter on June 1, a network adequacy report for all health insurance policies providing current coverage or new health insurance policies.
(2) Upon request by the Commissioner, a network adequacy report for all health insurance policies providing current coverage or new health insurance policies.
(3) Whenever an insurer seeks approval from the department for any policy form that relies upon or includes the option of utilizing contracted network providers to deliver ~~basic~~ health care services, the insurer shall at the same time file a network adequacy report for the policy form for which approval is sought.~~with the Policy Approval Bureau of the California Department of Insurance:~~
(b) Network adequacy reports, and accompanying documents, shall be electronically filed with the Health Policy Approval Bureau through the "California Life & Health" instance of the System for Electronic Rate and Form Filing (SERFF) of the National Association of Insurance Commissioners (NAIC).
(c) Network adequacy reports shall consist of:
(1) A report describing the number and location of all network providers by county or zip code, including facilities, primary care providers, specialty providers, and mental health providers, including behavioral health providers, utilized by the insurer to provide services to covered persons and demonstrating that the insurer is in compliance with all the accessibility and availability requirements of these regulations, and identifying the location and extent of areas of non-compliance~~, such as a report produced using GeoAccess GeoNetworks)software offered by Ingenix Corporation~~.
(2) A description of the service area covered by the network, by zip code, and describing any change to the service area since the filing of the most recently filed network adequacy report.
(d) The following documents must be submitted with the network adequacy report:
~~(2)~~ (1) An affidavit or attestation acknowledging compliance with all the requirements of this regulation.
~~(3)~~ (2) A copy of written procedures required by subdivision (b)(7) of Section 2240.1.

~~(4)~~ (3) Complete copies, including all appendices, attachments and exhibits, of the most commonly utilized network provider contracts for each type of provider the insurer (or its agent if using a leased network) includes in the provider network, including but not limited to hospital, individual physician, group physician, laboratory, mental health rehabilitation and ancillary service contracts. ~~Rates or rate schedules need not be provided with this filing.~~ All material changes to provider contracts must be filed with the Policy Approval Bureau as they become effective.

(4) Copies of all written policies and procedures for recruiting network providers, credentialing or accrediting network providers, contracting with network providers, and managing the insurer's networks, including the selection and tiering standards required by subdivision (g) of Section 2240.1.

(5) The mental health and substance abuse disorder access report required by subdivision (c)(5)(C) of Section 2240.1.

~~(b) Any insurer who by June 30, 2008 has not filed all of the information required by subsection (a) (1), (2), (3), and (4) pertaining to each network of providers used for delivery of medical services under any policy of insurance in force, sold or offered for delivery in California shall do so for each such network by that date.~~

~~(c) An insurer seeking approval for a new product which will utilize a network that has previously been described to or filed with the department pursuant to subsections (a)(1) or (b), may file an affidavit or attestation stating that the network to be utilized for the new product is substantially the same as one previously filed, and that there have been no material changes to the network that would result in failure to comply with any of the provisions of this article. Such affidavit shall clearly identify the previous filing, and shall, if appropriate, recalculate the ratios required by Section 2240.1(c)(1) taking into account projected new covered lives.~~

(6) The timely access standards set forth in the insurer's policies and procedures including, as may be applicable, any alternative time-elapsed standards and alternatives to time-elapsed standards for which the insurer obtained the Department's prior approval.

(7) A report regarding the rate of compliance, during the reporting period, with the time elapsed standards set forth in Section 2240.15(b). An insurer may develop data regarding rates of compliance through statistically reliable sampling methodology, including but not limited to provider and insured survey processes;

(8) A report regarding any noncompliance by the insurer with the provisions of this article. The report shall state whether or not an incident or pattern described in subdivision (d)(8)(A) or (d)(8)(B) below occurred during the reporting period and, if so, shall include a description of the identified non-compliance and the insurer's responsive investigation, determination and corrective action:

(A) Any incidents of noncompliance resulting in substantial harm to an insured, or

(B) Any patterns of non-compliance.

(9) A description of the implementation and use by the insurer and its contracting providers of triage, telemedicine, and health information technology to provide timely access to care;

(10) The results of the most recent annual covered person and provider surveys required by subdivisions (c)(2)(B) and (c)(2)(C), respectively, of Section 2240.15 and a comparison with the results of the prior year's surveys, if any such surveys were conducted, including a discussion of the relative change in survey results;

(11) Data regarding the extent to which members used out-of-network services during the reporting period, including the number of out-of-network claims by type of provider, dollar value

of total claims, average value per claim, total amount paid by the health plan, average amount paid per claim, total unpaid claim balances and average unpaid claim balance per claim.
(12) Data regarding the extent to which members used emergency room services during the reporting period.
(13) The information identifying and providing the location of each transplant center in the network by name and address, and type of transplant provided in the facility, required by subdivision (f) of Section 2240.1.
(14) Information confirming the status of the insurer's provider network and enrollment at the time of the report, which shall include, on a county-by-county basis, in a format approved by the Department:
(A) The insurer's enrollment in each product line; and
(B) A complete list of the insurer's contracted physicians, hospitals, and other contracted providers, including name, location, specialty and subspecialty qualifications, California license number and National Provider Identification Number, as applicable. Physician specialty designation shall specify board certification or eligibility consistent with the specialty designations recognized by the American Board of Medical Specialties.
(e) The information required by subdivision (d)(14) shall be included with the network adequacy report until the Department implements a web-based application that provides for electronic submission via a web portal designated for the collection of insurer network data. Upon the Department's implementation of the designated network data collection web portal, the information required by subdivision (d)(14) shall be submitted directly to the web portal.
(~~d~~f) An insurer must notify the department immediately at any time that a material change to any of its networks results in the insurer being out of compliance with any of the provisions of these regulations and, at the same time, submit a corrective plan specifying all actions that the insurer is taking, or will take, to come into compliance with these provisions, and estimating the time required to do so.
(~~e~~ g) Health insurers that contract for alternative rates of payment with providers shall annually submit a report to the Department through the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filing (SERFF), no later than March 31, ~~annually to the Consumer Services Division of the Department of Insurance~~ on complaints received in the previous calendar year by the insurer regarding ~~timely~~ access to care by covered persons and issues with contracted providers. This report shall include the following:
(1) ~~a~~ A summary of receipt and resolution of complaints from covered persons regarding access to or availability of any of the following services by type of service: primary care services, specialty care services, mental health professional services and hospital services.
(2) A summary of receipt and resolution of complaints received from providers by network and type of service: primary care services, specialty care services, mental health professional services, hospital services, and other services.
(3) The summaries required by subdivision (g)(1) and (g)(2) above shall include the following:
(A) Total number of complaints in the prior calendar year.
(B) Identity of complainant.
(C) Description of complaint
(D) Status of complaint as either resolved or unresolved.
(E) Date complaint received.
(F) Time from receipt of the complaint to resolution of the complaint, if applicable, or a statement that the complaint is unresolved.

(G) Reason or reasons for failure to resolve the complaint, if applicable.
(H) Description of complaint resolution, if applicable.
(h) The Commissioner may audit compliance with the requirements of this article through requests for additional background information regarding surveys undertaken by an insurer, and through direct surveys of providers and covered persons.
(~~f~~ i) The department shall review these complaint reports and any complaints received by the department regarding timely access to care and shall make this information public.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133 and 10133.5, Insurance Code.

Adopt new § 2240.6. Notice and Information to Covered Persons.
(a) Network provider directories shall be updated pursuant to the requirements set forth in this section and shall be offered to accommodate individuals with limited English proficiency or disabilities.
(b) An insurer shall post its current network provider directory on its internet web site and inform its covered persons of the availability of the internet network provider directory through its coverage materials. The network provider information provided on the website shall be updated weekly. The network provider directory shall be available online to both covered persons and consumers shopping for coverage without requirements to log on or enter a password or a policy number.
(c) An insurer shall maintain accurate provider directories for its networks as to the data elements listed in subdivision (g), below, and shall demonstrate the accuracy of its directories at the request of the Department.
(d) In addition to providing the network provider directory on its internet web site, the insurer shall also inform its covered persons of the availability of a paper copy of the network provider directory at no cost in its coverage material and on its internet web site.
(1) The paper copy of the network provider directory shall be printed annually and updated quarterly during the calendar year.
(2) An insurer may satisfy this quarterly update requirement by providing a paper copy insert or addendum to any existing paper copy network provider directory.
(e) If an insurer has more than one provider network, its provider directories shall make it reasonably clear to a covered person which network applies to each insurance product.
(f) The network provider directory shall inform covered persons regarding the availability of translations and interpreter services in languages other than English pursuant to section 10133.8 of the Insurance Code.
(g) The network provider directory shall list the following for each provider:
(1) The name of the provider,
(2) The specialty area or areas of the provider,
(3) Whether the provider is currently accepting new patients,
(4) Whether the provider may be accessed without referral,
(5) The location(s), including address, and contact information for the provider,
(6) The gender of the provider,
(7) Languages spoken by the provider,
(8) Languages spoken by office staff,

(9) List of network facilities where the provider has admitting privileges,
(10) Whether the provider is a primary care physician (PCP),
and
(11) Whether the office is ADA accessible.

(h) The network provider directories, both printed and online, shall also inform consumers of the requirements of this article regarding the insurer's obligation to offer consumers primary care and specialty care within the specified time frames.

(i) The network provider directories, both printed and online, shall identify those contracting providers who are themselves multilingual or who employ other multilingual providers and/or office staff, based on language capability disclosure forms signed by the multilingual providers and/or office staff, attesting to their fluency in languages other than English; changes to this information shall be reflected in provider directory updates.

(j) An insurer shall promptly notify those patients seen by a provider within the past year when the provider, for any reason, leaves the insurer's network. This may include but is not limited to the provider's decision to retire or stop practicing medicine for other reasons, relocating to an area outside the service area, leaving a group practice that is included as a participant in the network, or withdrawing from a network for any other reason.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133, 10133.5, and 10133.8, Insurance Code.

Adopt new § 2240.7. Discretionary Waiver of Network Access Standards.

(a) If an insurer is unable to meet the network access standard(s) required by this article, the insurer may apply to the Commissioner for a discretionary waiver of any network access standards and offer an alternate access delivery system. A waiver application must be resubmitted annually.

(b) An application for waiver shall only be reviewed and may be granted for the following reasons:

(1) Absence of practicing providers located within sufficient geographic proximity based upon the time or distance standards of this article.

(2) There are sufficient numbers or types of providers or facilities in the service area to meet the standards required by this article but the insurer is unable to contract with sufficient providers or facilities to meet the network access standards set forth in this article.

(3) An insurer's provider network has been previously approved under this article, and a provider or facility subsequently becomes unavailable within the service area.

(4) The inclusion in the application of a proposal regarding innovative network design, such as primary care medical homes, "Centers of Excellence," or accountable care organizations.

(c) In order for a waiver to be granted, the insurer must:

(1) Propose an alternate access delivery system that will provide covered persons with access to medically necessary care on a reasonable basis without detriment to their health.

(2) Ensure that covered persons obtain all covered services in the alternate access delivery system at no greater cost to the covered persons than if the services were obtained from network providers or facilities. Coinsurance, copayments and deductible requirements shall apply to alternate access delivery systems at the same level they are applied to in-network services.

(3) Demonstrate in its alternate access delivery system proposal a reasonable basis for not meeting any standard set forth in this Article, and include an explanation of why the proposed

alternative access delivery system provides covered persons with a sufficient number of the appropriate types of providers or facilities to which the standard in question applies.
(4) Demonstrate in its alternate access delivery system proposal how the insurer will assist covered persons to locate providers and facilities in a manner that assures both availability and accessibility.
(A) Covered persons must be able to obtain health care services from a provider or facility within the closest reasonable proximity of the covered person in a timely manner appropriate for the covered person's health needs.
(B) Alternate access delivery systems include, but are not limited to, such insurer strategies as use of out-of-county or out-of-service-area providers or facilities and exceptions to network standards based upon rural locations in the service area.
(d) The application shall include, at a minimum, the following:
(1) A description of the affected area and covered persons in that area and how the insurer determined the absence of providers or facilities.
(2) Alternatives that were considered, including but not limited to, telemedicine or phone consultation.
(3) The applicable reason or reasons set forth in subdivision (b).
(4) Any identified issues or risks that may prevent the alternate access delivery system from providing covered persons with access to medically necessary care on a reasonable basis without detriment to their health.
(5) The alternate access delivery system proposal described, and a description of how the proposed alternate access delivery system will satisfy the standards set forth, in subdivision (c).
(h) The Commissioner shall not approve an alternate access delivery system unless:
(1) The insurer provides substantial evidence of good faith efforts on its part to contract with providers or facilities and can demonstrate that there is not an available provider or facility with which the insurer can contract to meet the standards set forth in this article.
(2) The proposed alternate access delivery system will provide covered persons with access to medically necessary care on a reasonable basis without detriment to their health.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133 and 10133.5, Insurance Code.

OPPORTUNITY FOR INTERESTED PARTIES TO SUBMIT COMMENTS TO THE OFFICE OF ADMINISTRATIVE LAW

Paragraph (a)(2) of Government Code section 11346.1, and Insurance Code section 12921.7 require that, at least five working days prior to submission of the proposed emergency action to the Office of Administrative Law, the Department of Insurance provide a notice of the proposed emergency action to every person who has filed a request for notice of regulatory action with the Department. After submission of the proposed emergency to the Office of Administrative Law, the Office of Administrative Law allows interested persons five calendar days to submit comments on the proposed emergency regulations as set forth in Government Code section 11349.6. Information regarding the emergency regulations adoption process is available at http://www.oal.ca.gov/Emergency_Regulation_Process.htm.

EXPRESS FINDING OF EMERGENCY

CONTENTS

6) Statement Regarding Compliance with Notice Requirements (Gov. Code § 11346.1(a)(2), Ins. Code 12921.7)
7) Local Mandate Determination
8) Fiscal Impact Estimate
9) Studies and Reports
10) Appendix A: Description of Calculation of Mortality Risk Justifying Emergency
11) Appendix B: Further Detail Regarding Bankruptcy Impact Calculation
12) Contact Persons

INTRODUCTION

The Insurance Commissioner has determined that an emergency exists. This regulation is adopted on an emergency basis for the immediate preservation of public health and safety, and general welfare, within the meaning of Government Code section 11346.1.

The health insurance marketplace has undergone major, significant changes with the implementation of the federal Affordable Care Act and related state legislation. As a part of their response to these changes, health insurers, in some instances, restricted the scope of their provider networks, failed to provide sufficient capacity for specialty care, particularly regarding mental health treatment, and provided inaccurate information to consumers regarding their networks. Such conduct results in barriers to access to care, which result in increased severity of disease, poor health outcomes, and increased mortality. In addition, inadequate networks force consumers to resort to out-of-network care, exposing them to massive and crippling unanticipated costs. Because medical costs are a major factor in personal bankruptcy, networks that impede access to in-network care contribute to an increase in the risk of personal bankruptcy for Californians.

2014 was the first year in which the full sweep of the provisions of the Affordable Care Act were implemented. As the year progressed, the extent of problems related to provider networks and directories became manifest. The Department, anticipating the need to update its existing provider network regulation, initiated a series of public meetings to solicit input for possible changes to its regulation. The growing torrent of network problems that developed through the year, and the harmful impact on consumer health and finances that would result were these issues left to the regular rulemaking process, compel this finding of emergency for the immediate preservation of public health and safety, and general welfare, of the people of the State of California.

1) STATEMENT OF THE PROBLEM and SPECIFIC FACTS DEMONSTRATING EXISTENCE OF EMERGENCY

a. Insurance market changes lead to network designs that have deleterious health and financial consequences for consumers

With the passage of the Affordable Care Act, state insurance regulators face new challenges in ensuring that consumers are protected in a changing health insurance market. For example, in the individual market, the Affordable Care Act eliminated many of the means by which companies previously limited their claims expenses, such as through excluding consumers with pre-existing medical conditions through medical underwriting, or through imposing lifetime or annual maximum dollar limits on claims. Many insurers have responded to these and similar changes in the health insurance marketplace by offering health plans with narrow networks.

Over the past year, and increasingly in the last months of 2014, the Department has identified a persistent and serious problem with access to doctors, hospitals and other medical providers, as many health insurers reduced their provider networks and/or shifted to offering Exclusive Provider Organization (EPO) health insurance products with no out-of-network benefits except for emergency room visits. As a result, consumers complained of difficulty obtaining appointments with doctors and having to travel long distances to receive in-network medical care. In addition, health insurers' medical provider directories have been inaccurate, misleading consumers into signing up with a health insurer for access to a specific doctor, specialists or hospital only to learn that these medical providers are not actually a part of the health insurers network. Consumers have been forced to pay significant out-of-network charges when their health insurer fails to provide adequate medical providers in their network or when care is provided in network facilities by out-of-network providers. These emergency regulations are therefore necessary to assure that health insurers promptly establish and maintain adequate medical provider networks to meet the health care needs of their policyholders, maintain accurate provider directories, and avoid surprising consumers with huge charges for out-of-network providers who provide planned care, without prior disclosure to the insured person.

b. Industry Responses, Consumer Impacts

i. Narrowing of Networks Increase Out-of-Network Costs

A significant insurer response to the new competitive environment resulting from the Affordable Care Act was the creation of narrow networks, particularly in the individual and small group markets. Carriers consider narrow networks to be a means to control costs. In addition, narrow networks may act as a risk-selection mechanism, as individuals with greater care needs are likely

to be more attracted to broad network plans.[1] Unfortunately, this shift in network design exposed consumers to a higher risk of unexpected medical expenses.

The term 'narrow network' refers to offering plans that include substantially fewer providers than those typically included in networks for large employers (and, as a corollary, substantially fewer providers than are available in a given geographic area). For example, one carrier constructed a network for plans sold through the California Health Benefit Exchange, Covered California, that had less than a third of the physicians in Los Angeles County than the same plan offered to employers.[2] Another carrier restricted its Exchange customers to a network approximately half the size of its regular physician network.[3] A second approach employs a "tiered" network design, where consumers bear an increased cost-sharing burden if they choose non-preferred, but still in-network, providers. Third, changing the design of health coverage from a PPO (Preferred Provider Organization, which includes some coverage for out-of-network care) to an EPO (Exclusive Provider Organization, which does not pay for non-emergency out-of-network care) also functionally narrows the range of providers available to insured persons.[4] Major carriers changed their network approach in 2014, such that they only offered EPO plans to customers in some market segments in some of California's largest counties, such as Los Angeles, Orange, San Francisco, and San Diego.[5] Many consumers and providers, used to PPO coverage, are unfamiliar with EPOs, and their limitations.

A fourth method by which carriers narrow their networks is to limit geographic scope. For example, in 2014 carriers developed networks that limited prior geographic choices of providers, such that covered persons in Oakland or Marin Counties could not access San Francisco physicians or providers in-network.[6] Similarly, in 2014 some major health carriers stopped covering care for customers in border areas of the state whose nearest specialists were in large cities across the state border, such as Reno, where care was formerly covered. Instead, these

---

[1] Corlette S, Volk J, Berenson R, and Feder J. *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*, (May 2014) p. 2The Center on Health Insurance Reforms, Georgetown University/The Urban Institute. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413643

[2] Terhune, Chad. *Insurers Limiting Doctors, Hospitals in Health Insurance Market*.(September 14, 2013) Los Angeles Times. http://articles.latimes.com/2013/sep/14/business/la-fi-insure-doctor-networks-20130915

[3] *id.*

[4] Bartolone, Pauline. *Calif. Health Insurers Restrict Doctor Choice to Lower Cost.* (December 1. 2013). Capital Public Radio. http://www.capradio.org/articles/2013/12/01/calif-health-insurers-restrict-doctor-choice-to-lower-costs/

[5] Appleby, Julie. *'Narrow Networks' Frustrate Consumers in California and Nationwide* (July 28, 2014) The California Report: State of Health. http://blogs.kqed.org/stateofhealth/2014/07/28/narrow-networks-frustrate-consumers-in-california-and-nationwide/ , *also* Appleby, Julie. *Anthem Blue Cross Sued Over Covered California Doctor Networks* (July 9, 2014) The California Report: State of Health. http://blogs.kqed.org/stateofhealth/2014/07/09/lawsuit-anthem-blue-cross-committed-fraudulent-enrollment-practices/

[6] Dembosky, April. *Adequacy of Doctor Networks Key Issue for Covered California*. (May 22, 2014). The California Report: State of Health. http://blogs.kqed.org/stateofhealth/2014/05/22/adequacy-of-doctor-networks-key-issue-for-covered-california-narrow-networks/,

customers in rural border regions must travel hours, over mountain roads that may be dangerous or closed in winter, to access network providers.[7]

Narrow networks that exclude providers with specialized expertise are a fifth way insurers restrict networks. Narrow network designs can degrade the quality of care delivery, resulting in adverse health outcomes, while also subjecting consumers to unanticipated and potentially devastating financial liabilities.[8] Because of the lack of adequate and accessible specialized care for specific diseases in-network, consumers experience delays in obtaining needed care, or feel compelled to seek out-of-network care, sustaining a cost exposure substantially greater than they had anticipated when they purchased coverage. Such delays in care can result, for example, if a substantial number of network providers in a particular specialty lack privileges to practice at in-network hospitals.[9] Additionally, narrow network designs can result in care delays if network primary care providers cannot find network specialists for referrals; in a survey by the California Medical Association, 55 percent of responding physicians reported experiencing difficulty finding in-network specialists to whom their patients could be referred, particularly in fields that treat patients with chronic conditions, such as cardiology, oncology, and nephrology.[10]

The absence of needed specialist expertise also affects the realized actuarial value of the policy. While coverage in the individual and small group markets must now provide an actuarial value at "metal tier" levels specified in the Affordable Care Act, the actuarial value is calculated only on in-network coverage of essential health benefits.[11] Thus, if a network design leads to increased out-of-network care, the actuarial value actually delivered by a plan with a narrow network may be substantially less than the metal tier level would otherwise lead a consumer to expect.[12] As a consequence of these changes in network designs, consumers are more frequently exposed to

---

See also Bartolone, Pauline. *Calif. Health Insurers Restrict Doctor Choice to Lower Cost.* (December 1. 2013). Capital Public Radio. http://www.capradio.org/articles/2013/12/01/calif-health-insurers-restrict-doctor-choice-to-lower-costs/

[7] Bartolone, Pauline *California Border Residents Grapple with Out-of-State Health Insurance Restrictions* (December 16, 2014), Capitol Public Radio, http://www.capradio.org/articles/2014/12/16/california-border-residents-grapple-with-out-of-state-health-insurance-restrictions/

[8] Corlette, *supra*, p. 3

[9] As alleged in *Larue v. Health Net of California*, Los Angeles Superior Court action number BC 566095, filed December 9, 2014, regarding CommunityCare HMO Plan, also discussed in Gorn, David. *Health Net Sued Over Network Adequacy*.(December 12, 2014) CaliforniaHealthLine, http://www.californiahealthline.org/capitol-desk/2014/12/health-net-sued-over-network-adequacy , see also http://www.californiahealthline.org/~/media/Files/2014/PDFs/LaRue%20Complaint.ashx

[10] *Straightforward Contracting for a Stronger Health Care System*, (April 28, 2014). California Medical Association. http://www.cmanet.org/files/assets/news/2014/05/all-products-survey-final-043014.pdf
Also in Dembosky, April. *Adequacy of Doctor Networks Key Issue for Covered California*. (May 22, 2014). The California Report: State of Health. http://blogs.kqed.org/stateofhealth/2014/05/22/adequacy-of-doctor-networks-key-issue-for-covered-california-narrow-networks/

[11] Insurance Code section 10112.295(b)(2),10112.27

[12] Corlette, *supra*, p. 4

out-of-network bills. Such large and unexpected out-of-network bills now among the most common health-related complaints to state insurance departments.[13]

ii. "Hidden" out-of-network providers produce unexpected expense

As health carriers respond to the new competitive pressures in market after implementation of the Affordable Care Act, there is also a trend towards controlling costs by "hollowing" the network so that, while it may have sufficient facilities, such as hospitals, it fails to include needed specialists who have practice privileges within that facility. As a result, a consumer admitted to a network facility by a network provider (such as a surgeon) can nonetheless be confronted with unexpected bills from "hidden" non-network specialists, such as radiologists, anesthesiologists, pathologists, and assistant surgeons.[14] Even though Preferred Provider Organization (PPO) insurance coverage will pay a percentage of the costs of out-of-network care, the percentage is typically less than that paid for in-network care. Also, the 'allowed amount' that the insurer uses to calculate the percentage may be less than the total amount of the provider's bill, leaving the consumer liable for the remaining balance (referred to as "balance billing"). Similarly, while an emergency room might be in a network hospital, the physicians practicing within it may be non-network independent contractors, making consumers vulnerable to significant unanticipated costs.[15] The concern regarding "hidden" non-network specialists in network facilities is a national issue. A Texas study released in December, 2014, is indicative of the problem. Of the three largest insurers, the percentage of in-network hospitals with no in-network emergency room physicians ranged from 45 to 21 percent. For one insurer, 56 percent of its network hospitals had no in-network emergency room physicians; 8 percent of hospitals that contracted with the three largest insurers had no emergency physicians with contracts with any of the three insurers. Similarly, of the same three largest insurers, the average percentage of dollars billed by out-of-network specialists at in-network hospitals rages from 7 to 25 percent for anesthesiologists, from 8 to 15 percent for radiologists, and from 2 to 24 percent for

---

[13] For example, out-of-network bills are the most common complaint in New York. Crane, Kristin. *Socked with an Out-of-Network Medical Bill?*(August 13, 2014) US News & World Report, http://health.usnews.com/health-news/patient-advice/articles/2014/08/13/socked-with-an-out-of-network-medical-bill

[14] Bernard, Tara, *Out of Network, Not by Choice, and facing Huge Health Bills* New York Times (October 18, 2013) http://www.nytimes.com/2013/10/19/your-money/out-of-network-not-by-choice-and-facing-huge-health-bills.html?pagewanted=all&_r=1&

[15] Weissmann, Jordan, *Why Can't States Do More to Protect Patients from Surprise Medical Bills?* Slate (October, 2014) http://www.slate.com/articles/business/moneybox/2014/10/surprise_out_of_network_hospital_bills_why_it_s_so_hard_for_states_to_protect.html.

pathologists.[16] In another example, a non-network assistant surgeon, unknown and undisclosed to the patient prior to non-emergency surgery, billed $117,000 in unexpected charges.[17]

As discussed further below, these large, unexpected out-of-network charges for services scheduled in advance have a devastating financial impact on families. Given the magnitude of these impacts, and to avoid these consequences for Californians, this regulation is submitted on an emergency basis.

iii. Inaccurate Provider Directories

Another significant problem related to network design that had particular gravity as 2014 progressed was a widespread problem with the accuracy of carriers' network provider directories.[18] This was a particular issue for persons shopping for new or different coverage. Reliable information regarding which providers were included in-network was often difficult to obtain for those evaluating different plans, depriving consumers of the ability to make informed choices. For example, in a California Medical Association survey, 20 percent of responding physicians reported that carriers had mistakenly listed them as participating in certain networks.[19] And, when obtained, the provider directory information was often wrong, resulting in consumers being exposed to unexpected out-of-network charges for seeing their usual providers, even though they had checked the carrier's provider directory.[20] In addition, consumers experienced interruptions in the continuity of their care if they unexpectedly had to shift providers due to directory error.

The magnitude of the widespread problem regarding inaccurate provider directories was starkly demonstrated by the results of surveys released in November 2014 by the Department of Managed Health Care. In one such survey, "a significant percentage (12.5 percent) of the physicians listed in the directory were not at the location listed in the Provider Directory." Further, "a significant percentage (12.8 percent) were not willing to accept patients enrolled in

---

[16] Pogue, Stacey, *Surprise Medical Bills Take Advantage of Texans: Little-known practice creates a "second emergency" for ER patients* (September 15, 2014), Center for Public Policy Priorities, pp. 3, 5, http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf. Nationally, 65 percent of hospitals contract out their emergency room functions. Rosenthal, Elisabeth. *Costs Can Go Up Fast when E.R. Is In Network But The Doctors Are Not.* (September 28, 2014). New York Times. http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html?_r=0

[17] Rosenthal, Elisabeth. *After Surgery, Surprise $117,000 Medical Bill From Doctor He Didn't Know.* (Sept. 20, 2014). New York Times. http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html

[18] Appleby, Julia. *Consumer Group Sues 2 More Calif. Plans Over Narrow Networks.* (September 25, 2014). Kaiser Health News. http://kaiserhealthnews.org/news/consumer-group-sues-2-more-calif-plans-over-narrow-networks/

[19] *Straightforward Contracting for a Stronger Health Care System*, (April 28, 2014). California Medical Association. http://www.cmanet.org/files/assets/news/2014/05/all-products-survey-final-043014.pdf

[20] Terhune, Chad. *California Probes Obamacare Doctor Networks at Anthem and Blue Shield*. (June 20, 2014). Los Angeles Times. http://www.latimes.com/business/healthcare/la-fi-state-investigating-obamacare-networks-20140619-story.html

the Plan's Covered California products, despite being listed on the website as doing so."[21] Similarly, in a survey of another major carrier, "a significant percentage (18.2 percent) of the physicians listed in the directory were not at the location listed in the Provider Directory" and "a significant percentage (8.8 percent) were not willing to accept members enrolled in the Blue Shield's Covered California products, despite being listed on the website as doing so."[22] These findings, late in 2014, showed the urgent necessity of requiring accuracy in provider directories to avoid adverse health and financial impacts on California consumers.

c. Specific Facts Justifying Emergency: Delay in Regulatory Correction of Access Issues Increases Risk of Illness and Death

As demonstrated above, narrowing of networks and inaccurate provider directories results in delay in the provision of necessary health care. The Department has determined that such care delays can result in serious consequences, as a network that provides inadequate access to care produces results analytically similar to the health impacts seen among consumers who are uninsured or underinsured. Applying this analysis, the Department concludes that the delays inherent in implementing this proposed regulation through the non-emergency regulatory process will present the risk of the loss of between 17 to 42 lives, due to impaired access to health care, on an annualized basis.

The Department reached this conclusion by evaluating recent scientific papers as a basis for comparing various health outcomes of the uninsured, underinsured, and insured. When considered together, the seven papers showed ample evidence that uninsured or underinsured patients have worse health outcomes than patients with insurance. Delays in receiving care or non-existent care are barriers that result in worse health outcomes for individuals who are uninsured, underinsured, or have inadequate networks. Since the barriers to care experienced by consumers with inadequate networks are analogous to the barriers experienced by the uninsured and underinsured, the Department used the health outcomes of underinsured or uninsured individuals to estimate the health outcomes sustained by those whose care is impeded by an inadequate network. [23] The results of these studies are statistically significant, meaning that the differences between the groups in each study are unlikely to have happened by chance. The following is a summary of the most compelling results.

---

[21] *Final Report, Non-Routine Survey of Anthem Blue Cross, A Full Service Health Plan*. (November 18, 2014) Department of Managed Health Care. p. 3 http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf

[22] *Final Report, Non-Routine Survey of Blue Shield of California, A Full Service Health Plan*. (November 18, 2014) Department of Managed Health Care. p. 3, http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fsnr111814.pdf

[23] A comparison was necessary since there were no scientific papers specifically comparing the health outcomes of consumers who have adequate versus inadequate provider networks.

- In a 2013 study from *Health Services Research*, uninsured newborns were found to have decreased care and an increased risk of dying.
- In a 2012 study from the *Journal of General Internal Medicine*, uninsured status rather than race was strongly associated with death among those admitted to the hospital for a myocardial infarction (heart attack) or a coronary atherosclerosis event (plaque building up in the arteries).
- In a 2011 study from the *American Heart Journal*, lack of insurance and Medicaid insurance are both independently associated with an increased risk of dying in the hospital after undergoing a percutaneous coronary intervention (angioplasty).[24]
- In a 2007 study in the *Journal of General Internal Medicine*, patients without insurance had higher rates of stroke and death. They also had less awareness and control over their cardiovascular risk conditions.
- In a 2014 study in the *Journal of Surgical Oncology*, uninsured and Medicaid patients were more likely to have later stage tumors. Being uninsured or having Medicaid was independently associated with having a worse overall survival rate.
- A 2009 study in the *American Journal of Public Health* concluded that lack of insurance was significantly associated with mortality. In the US, this number may be as high as 44,789 deaths per year.
- In a 2007 study published in *Health Services Research*, veterans who visited a Veterans' Affairs medical center with wait times of more than 31 days had significantly higher odds of dying.

The seven studies above show a clear correlation between a lack of healthcare coverage and increased morbidity and mortality. Health coverage with networks that create barriers to care can result in outcomes similar to those seen with a lack of insurance; insurance without access to care is essentially equivalent to not having insurance. Health insurance networks with limited specialists or specialists located long distances from insured people present barriers to care which can result in worse health outcomes. For example, if a consumer experiencing numbness and tingling discovers there are no neurologists in her network, she may fail to obtain necessary tests because of the increased costs associated with out-of-network care. As a result, her condition could worsen, become more difficult and expensive to treat and have an adverse clinical outcome (increased morbidity). Likewise, a consumer whose cancer diagnosis is delayed because there are not enough oncology specialists in his network, or because specialists are too distant, or because specialists are not seeing new patients, or because they have no appointments available, could advance to late-stage cancer before the initiation of treatment. Beginning treatment when cancer has progressed to an advanced stage is associated with an increased risk of death (increased mortality). Conversely, health insurance networks with adequate numbers of providers, specialists, and facilities are more likely to provide consumers with timely access to

[24] Medicaid is used as a comparison for a narrow network since many providers limit the numbers of these insured patients or completely exclude them from their practices.

the health care they need. For example, in a non-narrow network a child with leukemia could more likely obtain appropriate tests and treatment from a pediatric specialist in a timely manner. The studies evaluated by the Department demonstrate that health outcomes of individuals with barriers to care will likely be less favorable than the outcomes of those with adequate access.

The Department concluded that health insurance policies with networks that present barriers to access will likely result in poor outcomes and worse morbidity and mortality of insureds compared to health insurance policies that are based on networks that offer adequate access. Using data from the above-mentioned studies, Department actuaries developed a model (discussed in detail in Appendix "A," below) to estimate the number of lives that might be placed at risk if the subject regulations are adopted through a non-emergency rulemaking process. Utilizing this model and the most up-to-date estimates of the parameters employed in the model, the Department estimates that delay inherent in the adoption of the proposed regulation on other than an emergency basis will threaten the loss of between 17 to 42 lives on an annualized basis.

d. Specific Facts Justifying Emergency: Financial Hardship and Bankruptcy

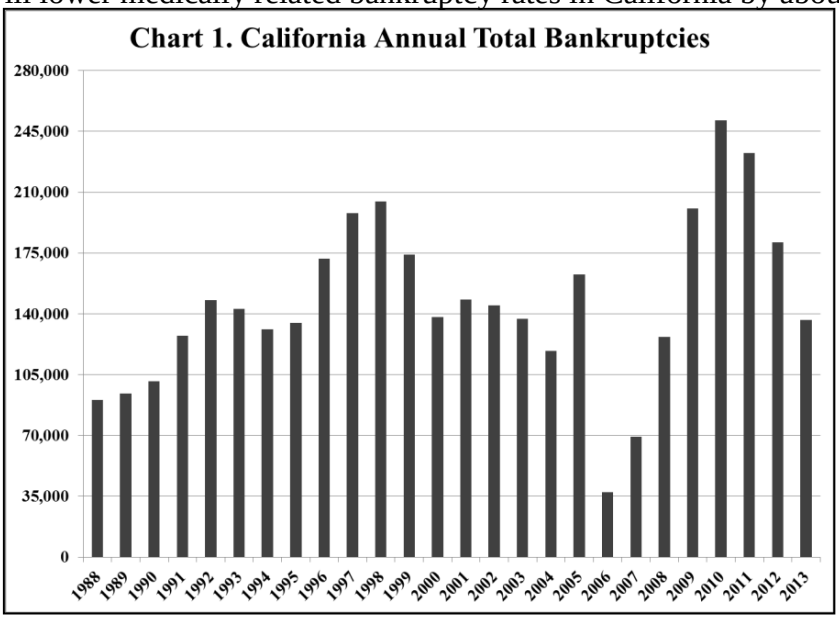
The significant and persistent pattern of problems that lead to increased exposure to out-of-network charges raises a serious risk of an increase in personal bankruptcies in California, with devastating personal consequences for the families involved. Unexpected medical bills threaten economic security, the ability to pay other obligation, and threaten bankruptcy.[25] Delays inherent in the implementation of the proposed regulation through the non-emergency process expose consumers to potentially crippling medical bills for out-of-network services. As a result, families risk the severe consequence of medical bankruptcy.

The Department has estimated the amount of money potentially lost by households who are in bankruptcy as a result of delay in the implementation of proposed regulations. Bankruptcy is a complex issue and the Department's estimate is focused only on those whose bankruptcies were related to significant medical bills ($5,000 or more). The financial impact of delay in implementing the proposed regulation assumes, once implemented, greater access to the financial security of in-network providers would enable families otherwise in difficult financial circumstances to avoid bankruptcy. The ripple effects of consumers or households avoiding bankruptcy are numerous including: medical providers being paid in full; other creditors, such as auto loan, home mortgage, student loan, and credit card companies being paid in full; and consumers themselves may benefit in many ways. Avoiding bankruptcy allows households to retain access to credit markets, saving them money on future debts since lower interest loans and

[25] Pogue, Stacey, *Surprise Medical Bills Take Advantage of Texans: Little-known practice creates a "second emergency" for ER patients* (September 15, 2014), Center for Public Policy Priorities, pp. 2, http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf

payments are usually only offered to those who have not had recent home foreclosures or bankruptcies. The effects of bankruptcy curtail households' access to inexpensive credit for seven years and sometimes longer. Bankruptcies may also limit access to certain jobs, limiting future earnings potential. In this analysis, however, the Department focuses solely on the potential lost benefit to households.

To estimate the impact of medical bankruptcies in California for 2013, the Department used data from the US bankruptcy courts which indicated that there were approximately 136,500 bankruptcy filings in California in 2013.[26] The 2013 data used in the following estimation by the Department is the most current available. Most likely, the effects of the ACA and an improving economy would show some further declines in total bankruptcies for 2014 and 2015. In particular, the Department expects that the extension of insurance coverage in 2014 and 2015 to those previously uninsured will lower medically related bankruptcy rates in California by about 5% from 2013 levels. The decrease in bankruptcies in 2006 was related to a change in bankruptcy laws. Since then, much of the volatility in bankruptcies over the last few years can be largely attributed to the housing foreclosure crisis, job loss/growth and the opportunities that come with business expansion, as California was hit harder in those areas than the nation. For the purposes of this analysis, the Department assumes that medically-related bankruptcies were relatively steady for the 2008-2013 time period. A small decrease in medically-related bankruptcies is projected for 2014 as health coverage expands under the ACA.



A clinical research study published in The American Journal of Medicine titled Medical Bankruptcy in the United States, 2007: Results of a National Study (MBUS) concluded that 62.1% of bankruptcies in 2007 were medically related, up from 49.6% in 2001, and 57.1% of bankruptcies were specifically attributed to problems with medical bills (the 5% difference being associated with persons who suffered loss of income due to illness). The lower percentage

[26] US Courts: Report F-5A. U.S. Bankruptcy Courts Business and Nonbusiness Bankruptcy County Cases Commenced, by Chapter of the Bankruptcy Code, During the 12- Month Period Ending December 31, 2013, http://www.uscourts.gov/Statistics/BankruptcyStatistics/2013-bankruptcy-filings.aspx

(57.1%) is more specifically related to the proposed regulation, with network adequacy and out-of-network (OON) billing problems, as opposed to the broader 62.1% of bankruptcies claimed to be medically-related (see Table 1).

In a paper responding to the first 2001 MBUS, Medical Bankruptcy: Myth Versus Fact, the authors claimed that medical bills are a cause of only 17% of bankruptcies, and that they are not the most important cause. They claim that the MBUS authors failed "to perform the multivariate statistical analysis necessary to determine the magnitude of the causal relationship or to rule out other factors such as loss of job, education expenses, or housing costs."[27] The second MBUS study published in 2009 and based upon 2007 data sought to rectify some of the problems with the earlier 2001 study. However, even with improvements in the MBUS methodology, the authors admit that, "Teasing causation from cross-sectional data is challenging."

Table 1. Bankruptcies Potentially Affected by the Proposed Regulation	
Total Bankruptcies in 2013	**136,529**
Bankruptcies from any Medical Cause	62.1%
Bankruptcies due to Medical Bills	57.1%
Remaining Bankruptcies	77,958
Bankruptcies with Private Insurance	60.3%
Remaining Bankruptcies	47,009
Drop in bankruptcies from 2013 due to expansion of medical coverage	5%
Remaining Bankruptcies	44,658
CDI Private Insurance Market Share	9.8%
Remaining Bankruptcies	4,377
Individual and Small Group Share of Bankruptcies	90.0%
Remaining Bankruptcies	**3,939**

CDI determined that, while recognizing the limitations of the MBUS study, its data provided a sufficient basis for CDI's estimates. If 57.1% of bankruptcies are due to medical bill problems, that means as many as 78,000 bankruptcies in California in 2013 were due to significant medical bills (136,529 bankruptcy filings x 0.571 = 77,958 or approximately 78,000). Using the MBUS study's average medical cost of $17,943 in 2007 and adjusting it for medical inflation implies $21,729 in average medical bills per bankruptcy in 2013.[28] Multiplying the 78,000 medically related bankruptcies by $21,729 in average medical bills implies an estimated $1.7 billion burden to California in 2013. The significance of mounting OON medical bills is part of a broader and very complex problem, as stated in the MBUS study. However, CDI's proposed regulation will still help to address the growing problem of medically-caused bankruptcies.

[27] Medical Bankruptcy: Myth Versus Fact, David Dranove and Michael L. Millenson, published online February 28, 2006; 10.1377/hlthaff.25.w74, Health Affairs, 25, no.2 (2006):w74-w83, http://content.healthaffairs.org/content/25/2/w74.full.html

[28] Bureau of Labor Statistics: Consumer Price Index - All Urban Consumers: Item: Medical Care Series ID: CUUR0000SAM, Accessed August 6, 2014, http://data.bls.gov

Actuarial Analysis

Department actuaries conducted an extensive review of in-network versus out-of-network costs and evaluated the distribution of medically-related bankruptcies. The Department estimates that, based on the expected in-network versus out-of-network cost breakdown for an ACA silver plan, the proposed regulation would save consumers 2.5% in out-of-pocket medical expenses, equating to a savings of $546 per household.

Table 2. Estimated Impact on Bankruptcies from Expanded Networks				
	Before Regulation	After Regulation	Change (#)	Change (%)
Bankruptcies	3,939	3,916	23	-0.6%
Avg Medical Debt	$ 21,494	$ 20,948	$ 546	-2.5%
Total Medical Debt	$ 84,666,534	$ 82,025,824	$ 2,640,710	-3.1%

However, bankruptcy is a very complex issue in which bankruptcy filers often have more than one creditor. For analytic purposes, the Department's calculation focuses on those who might be helped by this regulation and have significant medical bills. The calculation also assumes that in the 3,939 cases that might benefit from the proposed regulation, the medical debt is what compels the household in debt to eventually file for bankruptcy. Given those assumptions, the expected shift in the distribution of medically related bankruptcies caused by the $546 savings per household would imply that, were the regulation to be delayed through a non-emergency adoption process, an estimated 23 California households would be at risk for filing for bankruptcy, on an annualized basis, during the non-emergency rulemaking period. The 23 households represent those most likely to file for bankruptcy because of medical debts, but would be saved from doing so because of adoption of this regulation on an emergency basis. As seen in Table 2, total out-of-pocket expenses would decrease, were the regulation to be adopted on an emergency basis, by about 3.1% for the affected population ($84.7 million x 3.1%), or $2.6 million.

e. Why this matter is not addressed through Non-Emergency Regulations (Gov. C. § 11346.1(b)(2))

Consistent with its responsibilities under Insurance Code section 10133.5(g) to review its existing provider network adequacy regulation to "determine if the regulation should be updated to further the intent of this section," the Department initiated a process of public input, holding public meetings on December 10, 2013 and June 30, 2014 regarding potential revisions to the regulation. However, as 2014 progressed, and particularly at the end of the year, the exceptional gravity of the consumer impacts arising from recent changes in network practices, and deficiencies in network directories, compelled the Department to conclude that addressing these issues through a non-emergency rulemaking process would imperil the health and finances of

Californians, as demonstrated above, due to the inherent delays involved in the non-emergency rulemaking process. Further, the federal government issued a proposed rule on November 26, 2014 that would revise 45 C.F.R. 155.410 (e) to advance the opening of open enrollment in the individual and small group markets from November 15 (as in 2014) to October 1 in 2015.[29] Thereafter, in December, 2014 Covered California released a proposal that carrier applications for new entry or recertification in the Exchange would be due May 1, 2015.[30] Given these deadlines for 2016 coverage, non-emergency rulemaking process would not permit a regulation to become effective in sufficient time to inform insurance companies regarding network design requirements prior to their design and submission of their policy forms and networks for the 2016 coverage year.

2) AUTHORITY AND REFERENCE

The proposed regulations will implement, interpret, and make specific the provisions of Insurance Code sections 106, 10112.27, 10133, 10113.5, 10133.8. Subdivisions (a) and (g) of Insurance Code section 10133.5 provide authority for this rulemaking.

3) INFORMATIVE DIGEST (Gov. C. 11346.5(a)(3))

a. SUMMARY OF EXISTING LAW AND REGULATIONS

In the 2002 session, the Legislature enacted Assembly Bill 2179, which required that the Department of Insurance and Department of Managed Health Care (DMHC) promulgate regulations to "ensure that insureds have the opportunity to access needed health care services." (Insurance Code section 10133.5(a)).[31] Insurance Code section 10133.5(b) provides that the regulations must assure:

- Adequate numbers and locations of facilities, providers, and specialists, in relation to projected demand for services
- That the insurance contract is not inconsistent with good health care and clinically appropriate care, and
- That contracts with providers and facilities be fair and reasonable.

In enacting Assembly Bill 2179, the Legislature made the following finding:

---

[29] http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf

[30] *QHP New Entrant Certification Application for Plan Year 2016*, (December 22, 2014). Covered California. Slide 5, "Draft Proposed Recertification/Certification Timeline for Plan Year 2016" http://hbex.coveredca.com/stakeholders/plan-management/PDFs/12-22-14%20QHP%20New%20Entrant%20Draft%20Application%20Review%20Webinar%20Presentation.pdf

[31] AB 2179 also amended Health and Safety Code sections 1342 and 1367, and added Section 1367.03 to require a similar, but not identical, regulatory response from the Department of Managed Health Care.

> It is the intent of the Legislature to ensure that all enrollees of health care service plans and health insurers have timely access to health care. The Legislature finds and declares that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population. It is the further intent of the Legislature in enacting this section that the department shall incorporate the standards developed under this section in licensing, survey, enforcement, and other processes intended to protect the consumer.

The existing regulation, title 10 California Code of Regulations sections 2240 through 2240.4, amended a previous regulation promulgated in 1984 that applied to Exclusive Provider Organizations ("EPOs"). In response to Insurance Code section 10133.5, the existing regulation was amended in 2008 to include Preferred Provider Organizations (PPOs). As amended in 2008, the regulation added definitions relevant to network adequacy, expanded the scope of the regulation to include PPOs, provided time and distance standards for primary care providers, specialists, mental health professionals, and facilities, and the requirement that insurers submit a network adequacy report, exemplar provider contracts, and written procedures regarding evaluating access to care.

b. POLICY STATEMENT OVERVIEW: OBJECTIVES AND BENEFITS

As discussed in Section (2), above, "Statement of the Problem and Specific Facts Demonstrating Existence of Emergency," changes in the health coverage market place have resulted in reduction in the size and scope of medical provider networks, and inaccurate provider directories. These and other trends have significantly increased the risk that consumers will experience negative health outcomes and/or incur unexpected out-of-network costs and delays in care due to inadequate networks and incorrect provider directories. This emergency regulation amends the Department's existing provider network adequacy regulation to strengthen requirements regarding network design, demonstration of insurer compliance, submission of data that will support the analysis of emerging trends, as well as requirements regarding accuracy of provider directories and other consumer notices.

The proposed regulation will update the Department's existing regulation, and address concerns regarding inadequate network access, non-network providers in network facilities, and inaccurate provider directories, by implementing the following proposed amendments and additions in this regulation:

c. SPECIFIC PURPOSE OF THE REGULATION AND DESCRIPTION OF NECESSITY

Amend section 2240, "Definitions"

The existing subdivision (a), regarding "basic health care services," is deleted. This deletion is necessary for clarity, so that insurers can understand the scope of the revised regulation. The proposed revised regulation addresses an emergency arising from network designs that are inadequate to provide for medically necessary care of insured persons. The term "basic health services" includes, at current subdivision (a)(8), "any other health care or supportive services that are covered pursuant to an insurance contract." Because of this provision, the term "basic health care services" is coextensive with the coverage under the contract itself, and so is not a term of limitation. The term "basic health services" does not define a subset of the insurance coverage, but rather the entire coverage. However, the term now carries the risk of confusion with the term "essential health benefits," which defines minimum benefit requirements for the individual and small group markets (Insurance Code section 10112.27), and maximum out-of-pocket limit in the large group market (Insurance Code section 10112.285(d)). Therefore, deletion of this phrase from this subdivision, and its use in current subdivision (c) [proposed subdivision (b)], current subdivision (c) [proposed subdivision (b)], and section 2240.1 subdivisions (b)(3),(4),(6), and 2240.5(a)(2) is necessary to avoid confusion, and to address the emergency by making clear that the network access requirements of the regulation apply to all covered health care services, rather than merely to a subset of those services.

Existing subdivision (e), renumbered as (d), "Emergency health care services," is refined to make clear that the scope of the term includes the criteria provided in Health & Safety Code section 1317.1(b), and that it encompasses psychiatric emergencies. This clarification of the definition is necessary to assure that networks are designed to provide access for the full range of emergency conditions.

New subdivision (e) provides a definition of "essential community provider." Essential community providers are providers who predominantly serve low-income, medically underserved individuals. The Affordable Care Act requires that plans sold within Covered California include essential community providers in their networks, so that newly-insured, but previously medically underserved, persons will have access to providers in their community. As essential community providers are required in networks for plans sold within Covered California, it is necessary, in order to provide guidance to insurance companies in order to assure access to these providers, to provide a definition. The definition refers to, and is consonant with, the federal definition at 45 CFR § 156.235, and mirrors the definition adopted by Covered California at title 10, Cal. Code Regs. § 6410. This definition is then used in proposed new subdivision (i) of 2240.1, which includes essential community providers within the set of categories that must

be included in evaluating network adequacy, and in proposed subdivision (c) of section 2240.4. This definition is necessary for the Department to enforce these new requirements, in order to assure access to these providers.

New subdivision (o) provides a definition of "limited English proficiency." This definition is used in new section 2240.6(a), which requires that network provider directories be offered that accommodate individuals with limited English proficiency. This requirement, and the associated definition, is necessary in order to provide actual access to vital health coverage for all insured persons, including those with limited English proficiency. Absent such a requirement, affected individuals will be impeded from obtaining timely care, placing their health at risk.

The subdivision letter designations for "Certificate" (formerly subdivision (b), now (a)), "Covered Person" (formerly subdivision (c), now (b)), "Dependent Covered Persons" (formerly subdivision (d), now (c)) and "Emergency health care services: (formerly subdivision (e), now (d)) were changed due to the deletion of former subdivision (a), "basic health care services." This change is without regulatory effect, as it does not materially alter any requirement, right, responsibility, condition, prescription, or other regulatory element of any provision of the California Code of Regulations (title 1, Cal. Code Regs. § 100).

Amend section 2240.1: Adequacy and Accessibility of Provider Services

Section 2240.1 acts, along with new section 2240.15, as the core of this regulation.
Section 2240.1 provides standards for the assessment of a provider network at its inception, and periodically thereafter. Section 2240.1 provides time and distance standards, and other criteria, that make possible the determination of network adequacy on a prospective basis. The standards and criteria it provides affords a means to test the structural adequacy of a network, answering the question; "Will this network provide adequate access for the current and anticipated insured population?"

New section 2240.15, largely consisting of language adopted from the DMHC regulation (title 28, Cal. Code Regs. § 1300.67.2.2) provides additional standards for network design (appointment waiting time). In addition, however, these standards lend themselves to a retrospective evaluation of the actual performance of the network. Through survey and other methodologies, it concerns itself with the consumer experience of access through the measure of appointment waiting times. It provides a means to test the functional adequacy of a network, answering the question "IS this network providing adequate access for the consumers it serves?"

In light of the strains on network adequacy described in "Statement of the Problem," above, the additional network criteria added to this section and described below are necessary to address the emergency by assuring actual access to the full range of services that applicable law, and the

insurance contract, obligates the insurer to provide. Insurance Code section 10133.5 provides a broad grant of authority "to ensure that insureds have the opportunity to access needed health care services in a timely manner." The amendments to section 2240.1, and the addition of new section 2240.15, address factors that recent experience has shown act as barriers to that access.

The proposed amendments to section 2240.1(a) are necessary to provide clarity as to the scope of network requirements applied to dental and vision benefits. Denial of meaningful access to these services contributes to the heightened risk of negative health outcomes and financial woes detailed in "Statement of the Problem," above. The descriptive term "supplemental policies" to describe vision-only and dental-only policies is changed to the statutory term "specialized policies," in order to satisfy the clarity standard of the Administrative Procedure Act (the APA). Subdivision (c) of Insurance Code section 106 was added by AB 1750 in 2007 to provide a definition of vision-only and dental-only policies as "specialized health insurance" policies. This amendment updates and clarifies the regulation by bringing it into conformity with the statutory term so that the regulations will provide a comprehensive response to the identified emergency for insureds under Department-regulated health insurance products.

Subdivision (a) of section 2240.1 is also amended to reflect changes in law since it was last amended. Prior to the enactment of the Affordable Care Act, policies of health insurance were not required to include dental or vision coverage, and so providers of dental and vision care were not required to be included in networks (except in limited circumstances). However, the Affordable Care Act included pediatric vision and oral care services as a part of the array of essential health benefits that must be covered by individual and small group policies. California implemented this aspect of the Affordable Care Act by enacting Insurance Code section 10112.27 (SB 951 (2012)), which requires and describes the coverage of these benefits at subdivisions (a)(1),(4), and (5). This amendment of section 2240.1 of the regulation is therefore necessary to require the inclusion of providers of the pediatric oral and vision essential health benefits in health insurance network. The access standards for the provision of the pediatric oral and vision essential health benefit is provided at new section 2240.16. Section 2240.16 is necessary in order to provide access standards for these specialized benefits; the particular standards selected are appointment waiting time standards, rather than time and distance standards. This selection reflects the fact that the needs of the population receiving this benefit, and the nature of the practices of the professionals that provide pediatric oral and vision care, differ from those that apply to health benefits in general. The differences in the access standard selected reflect these differences.

Subdivision (b)(1) is amended to substitute "capacity, and specialty" for the words "or size" in describing attributes of network providers. This change is necessary to implement the mandate of Insurance Code section 10133.5(a), which is to assure actual access, and to address the emergency, which in part arises from networks that lack capacity to provide timely access to new

covered persons. The size of a facility or medical group is irrelevant if it does not have actual, available capacity, and the appropriate specialists, sufficient to accommodate the health needs of a carrier's insured person. Static size doesn't assure access; dynamic capacity does.

As discussed above pertaining to the "definitions" section, section 2240, the term "basic" is stricken from the phrase "basic health services" in section subdivisions (b)(3),(4), and (6). This change is necessary to satisfy the clarity standard of the Administrative Procedure Act, and to address the elements of the emergency where networks prove to be inadequate for some specialist categories. This change is necessary to avoid confusion, and to make clear that the network access requirements of the regulation apply to all covered health care services.

Existing subdivision (b)(7) required the monitoring of appointment waiting times as a part of an insurer's system for monitoring accessibility. New section 2240.15 adds prescriptive waiting time requirements; a reference to the new section is therefore added here for clarity. This addition is necessary to facilitate compliance with the new appointment waiting time requirement, which is added to address the network access concerns that are the basis for the emergency.

New subdivision (c)(3) requires that networks have sufficient primary care physicians in the network sufficient to accommodate anticipated enrollment growth. This requirement is necessary to assure actual access, particularly in a time when a large number of newly insured persons are placing increased demands on the health care system. Standards based solely on number and location of providers does not address the problem of a new customer who cannot find a network physician who takes new patients. A network that cannot accommodate new members is narrow and inadequate, and is a cause of the emergency the proposed regulations are intended to address. Complaints regarding this issue are commonly reported to the Department, as well as being reported in the media. This provision is necessary to address this problem.

Subdivision (c)(5), regarding network requirements for mental health services, provides necessary detail regarding the scope of insurer obligations regarding mental health networks. The Department has determined, based on analysis of existing networks regarding network inadequacy for mental health services, and in particular regarding adequacy of networks and actual functional access to behavioral health services for autism and pervasive developmental disorder, that these more specific criteria are necessary in order to assure access to these vital services. Absent such specific criteria, inadequate mental health networks would continue to contribute to the emergency that the proposed amendments are designed to address.

The definition of essential health benefits incorporates, at subdivision (c)(2)(D) of Insurance Code section 10112.27, the federal requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 100-343), and related

provisions of the Public Health Service Act (42 U.S.C. sec. 300gg-26). As a result, coverage of services for mental health and substance use disorder services are essential health benefits in California. Accordingly, subdivision (c)(5) is amended to make explicit the requirement that substance use disorder professionals must also be included in networks. This amendment is necessary to assure access to these required services, the effective denial of which services would otherwise continue to contribute to the emergency the proposed regulations are intended to address.

Subdivision (c)(5) is also amended to highlight the requirement that networks must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy (Insurance Code section 10144.51). The amendment also requires that mental health networks take into consideration the pattern and frequency of treatment. Some intensive therapies, such as Applied Behavioral Analysis therapy, require frequent treatment (in intensive circumstances, in excess of 25 hours per week), for which extended travel time by young children would be inappropriate. Providing such services at locations that make accessing the service at the frequency required to maximize success creates a bar to access, contributing to the access issues that give rise to the emergency. This amendment requires that such services be provided in closer proximity if clinically necessary. This amendment is necessary to address the emergency so that that network designs do not serve as functional impediment to effective treatment.

New subdivision (c)(5)(A) specifies services that mental health networks must provide. The services specified reflect the essential health benefits requirements of Insurance Code section 10112.27(a)(2)(A). This listing is necessary to address the emergency to prevent network designs that fail to include providers and facilities sufficient to provide the types of care required by the specific benefits to provide requirements for the services that must be provided within adequate mental health networks.

New subdivision (c)(5)(A) also specifies that networks must include services for the diagnosis and treatment of severe mental illnesses of persons of any age, and for the diagnosis and treatment of severe emotional disturbances of a child, as required by Insurance Code section 10144.5(a), and that the services available for such treatment include residential care ((*Harlick v. Blue Shield of California* (2012) 686 F. 3d 69, *Rea v. Blue Shield of California*, (2014), 226 Cal. App. 4th 1209, review denied (Sept. 10, 2014)). This amendment is necessary to address the emergency in order to incorporate these legal requirements into the regulation for clarity of guidance, and to facilitate subsequent enforcement.

New subdivision (c)(5)(A) also requires that networks include sufficient numbers of mental health providers, and that insurers must develop a standard for the design of their respective networks that takes into account the various types of mental health practitioners, including the range of professionals involved in behavioral health treatment, as described in Insurance Code

section 10144.5(c). This section is necessary to address the emergency in order to assure that networks include all of the types of mental health professionals needed to address the various needs of patient populations, in order to avoid situations where a network might have such a narrow design that it would not have appropriate professionals with the skills and competence necessary to address different patient needs.

New subdivision (c)(5)(B) responds to that aspect of the emergency that arises from the Department's analysis of inadequate mental health networks, in particular regarding behavioral health therapy as described in subdivision (c) of section 10144.51 of the Insurance Code. In order to assure access for these vital services, this section requires insurers to develop standards, approved by the Department, for the number and distribution of the various types of their licensure, including those described in subdivision (c) of section 10144.51 of the Insurance Code (qualified autism service providers, qualified autism service professionals, qualified autism service paraprofessional). Development, submission, and review of these standards will provide the Department with an additional means to prospectively assess the adequacy of mental health networks, require correction when needed, and in so doing abate the access limitations which form the basis of the emergency.

New subdivision (c)(5)(C) recognizes the unique challenges of designing mental health networks by requiring a narrative report from the insurer, on an at least annual basis, describing how its mental health network meets the specific mental health network criteria described in this section. This narrative report is in addition to the overall network adequacy report required by section 2240.5. In the experience of the Department, adequacy of mental health, and particularly behavioral health, networks has been an area of particular challenge for the industry. The emergency that justifies this regulation arises, in part, from network designs that narrow and confine the scope of networks, particularly mental health networks. This subdivision is necessary to address this aspect of the emergency, as it provides a means assure that networks, particularly narrow networks, include adequate provision for mental health diagnosis and treatment by providing the Department a means to monitor compliance.

New subdivision (c)(5)(D) requires that the design of mental health networks assure access through consideration of normal utilization patterns. This is necessary to address the emergency to assure that the network does not just address numbers and locations of consumers and providers, but also be designed to accommodate the expected demands for specific kinds of surgery.

New subdivision (c)(5)(E) requires access to customer service representatives who can respond to requests from covered persons regarding mental health and substance abuse disorder benefits. This new subdivision is necessary to address the emergency because being able to obtain answers to questions about how a covered person can access benefits is prerequisite to being able to access the benefit. Absence of answers creates a barrier to access.

Subdivision (c)(6) is amended to require that networks are designed so that network hospitals, in addition to meeting the existing time and distance standards, also have sufficient capacity to serve the expected utilization patterns of the population. This amendment is necessary to address the emergency in order to assure that there is not a mismatch between the expected pattern of the covered population's utilization of hospital services, and the actual nature and location of the hospital services, as such a disparity between services and need for those services would otherwise create a potential barrier to access to care.

Subdivision (c)(7) requires that there be an adequate congruence between the primary care providers and specialists in a network, and the network's hospitals. This requirement seeks to avoid network designs where there are inadequate numbers of network providers with admitting privileges at a network hospital for the particular treatment that a given consumer needs. This amendment addresses the emergency by assuring access by requiring that various components of a network, in this instance provider privileges and network facilities, mesh together in order to create a functioning health care delivery system.

New subdivision (c)(8) amends section 2240.1 to require access to retail pharmacies, laboratory services, and other services dispensed by provider prescription as an essential part of the health care delivery system. Insurance Code section 10133.5(a) requires that these regulations "ensure that insureds have the opportunity to access needed health care services in a timely manner." This addition to the regulation is necessary to address the emergency in order to assure that networks are not so narrow that they fail to adequately provide for pharmacy and laboratory services.

New subdivision (d) amends section 2240.1 to require that networks be designed to optimize access by using a variety of facility types, such as ambulatory surgery centers, and, further, that access be designed to accommodate the intensity and frequency of use by patients. This amendment is necessary to address the emergency, which emergency is based in part on access problems in network design. The proposed subdivision (d) sets as a requirement the optimization of access through use of a range of facility types, as opposed to a network design that restricts access to a narrow subset of facilities. Also, proposed subdivision (d) is necessary so that networks will be designed such that network facilities that patients must use frequently, such as dialysis centers, which a given patient might use multiple times per week, are located so as to avoid long, disruptive or prohibitive travel times.

New subdivision (e) amends section 2240.1 to require that, if a network cannot provide medically appropriate care required by a patient, the insurer shall arrange for care out-of-network, with the patient responsible for paying only the in-network cost-sharing. This provision is necessary to address the emergency by assuring that, if a network design is so narrow that it cannot provide the specific care a covered person needs, the care will be provided outside the network. Insurance Code section 10133.5(a) provides that these regulations are to "ensure that insureds have the opportunity to access needed health care services." Similarly,

10133.5(b) provides that the "regulations shall be designed to assure accessibility of provider services in a timely manner to individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract." In the context of a PPO network, "access" includes the ability to realize the benefits of the PPO coverage contract by being able to access needed health services within the network at in-network cost sharing. A network that cannot provide a needed provider service is inherently inadequate, and necessarily erects barriers to access when covered persons must pay additional out-of-pocket payments for out-of-network care in order to receive those services which the insurer is legally obligated to make available in-network. In order to achieve the required access, it is necessary for the proposed regulations to specify that in such a case the insurer must provide the appropriate care at in-network cost sharing. .

New subdivision (f) amends section 2240.1 to require that a network must demonstrate the capacity to provide necessary transplant services, and to include the identity, location, and transplant capability of each network center in its network. This amendment is necessary to address the emergency to provide transparency regarding a network's transplant capability. Typically, transplants are only performed in a limited subset of a network's facilities. Typically this includes academic medical centers and other centers of excellence. A coarse reporting of facilities is insufficient to show this level of fine detail. In an era when networks are being narrowed, both in terms of size and in the geographic range of options available to covered persons, this requirement is necessary so that networks will have the necessary capacity for these vital services, and so that the Department will receive the data needed in order to ensure compliance.

New subdivision (g) of section 2240.1 addresses another aspect of the emergency, the criteria used to select providers and facilities for the network, as well as the criteria used to tier the providers and facilities at different levels of cost-sharing expense to the covered person. While selective contracting with providers and facilities based on cost and quality is a means by which insurers can enhance the value of the coverage, the increasing prevalence of narrow, restricted networks (and, in particular, Exclusive Provider Organization arrangements), makes it necessary that the selection of network participants be subject to standards provided to the Department. Providing this information will enable the Department to analyze the provider-selection component of network design so as to assure that the criteria take into account the geographic proximity requirements of this article and quality of care and health outcomes, in order to assure that the network will in fact provide actual access to needed health care services. In addition, providing the provider and facility selection standards will assure that a narrow network design cannot be used as a pretext for a discriminatory design that would avoid geographic areas where provider treats populations with higher than average health care claims, or that would exclude specialty types that treat populations with risk of serious or chronic disease higher than those of the general population. In similar fashion, new subdivision (h) prevents discrimination against low-income populations by assuring that networks include essential community providers

(providers that serve predominantly low-income, medically underserved individuals, defined at proposed subdivision (e) of section 2240). This provision is necessary to address the emergency, so that narrow- restricted network design will not be used as a pretext to exclude or discourage certain particularly vulnerable populations from seeking coverage and access to care. For example, a network whose service areas included concentrations of low-income persons that excluded essential community providers who practice in the low-income areas would, by so doing, erect barriers to access by contracting with providers at a distance from the low-income community. Low-income communities are particularly sensitive to the cost of transportation; a network design that requires departure from the community and transportation to distant providers establishes a barrier to access and care, discouraging effective health management and increasing morbidity and poor health outcomes. The proposed amendment, which prohibits discrimination against essential community providers, addresses this aspect of the emergency.

New subdivision (i) provides that networks that include mountainous rural areas shall take typical patterns of winter road closures into account. This reflects the concerns regarding covered persons who might otherwise have to cross high mountain passes in winter, as discussed above in "Statement of The Problem." For example, covered persons on the east slope of the Sierra in communities such as Quincy or Truckee, who may be able to access specialty care in Sacramento when the mountain passes are open, may be barred from effective access to care because of winter road closures. For such patients, having care alternatives available that do not involve snowbound mountain passes, such as in Reno, may be necessary to provide needed access.[32] Further, the proposed amendment is consistent with the Department's obligation to "consider the accessibility to provider services in rural areas." (Insurance Code section 10133.5(c)). This subdivision is necessary to address the emergency, in light of the documented problems with winter access in rural areas.

The concerns raised regarding network adequacy after implementation of the Affordable Care Act reveal a manifest need for insurers to monitor and manage their networks to assure ongoing access to health care for their customers. New subdivision (j) of section 2240.1 addresses this aspect of the emergency by requiring that insurers measure the adequacy of their networks at least twice a year, and demonstrate to the Department that they have done so, in order to assure ongoing compliance, so that access, in turn, may be assured. The Department has determined that an assessment of network adequacy at least twice a year appropriately balances the need to maintain the ongoing ability to provide the required access with the costs to insurers of undertaking the assessment.

New subdivision (k) of section 2240.1 addresses the emergency by providing that the Insurance Commissioner may exercise discretion to require an insurer to adjust its network where required by the medical needs of the consumers it serves. This amendment is necessary in order to

[32] *see, for example*, Bartolone, Pauline. California Border Residents Grapple with Out-of-State Health Insurance Restrictions (December 16, 2014), Capitol Public Radio, http://www.capradio.org/articles/2014/12/16/california-border-residents-grapple-with-out-of-state-health-insurance-restrictions/

provide for network changes, when needed in particular circumstances, to assure access. For example, if the Department determines that a behavioral health network, which otherwise meets the general time and distance standards of subdivision (b) of section 2240.1, nonetheless provides inadequate access because of the frequency and intensity of the type of treatment, this new subdivision permits the Commissioner to require modifications to the network in order to assure actual access, and in so doing addresses the access issues related to the emergency.

Former subdivisions (c)(6) and (d) of section 2240.1 are renumbered as subdivisions (l) and (m), respectively, due to the addition of the subdivisions discussed above.

Former subdivision (c)(7) of section 2240.1, which dealt with discretionary waivers of network requirements, is deleted and replaced by new section 2240.7.

New section 2240.15: Network Access Appointment Waiting Time Standards; Quality Assurance; Disclosure and Education

New section 2240.15 frames new appointment waiting time standards, which the Department has determined are necessary as a further means of assuring and monitoring the functional access of health insurance networks for consumers. As discussed above, New section 2240.15, largely consisting of language adopted from the DMHC regulation (title 28, Cal. Code Regs. § 1300.67.2.2), provides additional standards for network design (appointment waiting time). In addition to providing more specific guidance as to design, however, these standards lend themselves to a retrospective evaluation by the Department of the actual performance of the network. Through survey and other methodologies, this new criterion concerns itself with the consumer experience of access through the measure of appointment waiting times. Because narrow networks, and other recent restrictive changes in network designs, can have an impact on the consumer's actual ability to access care (by making it difficult to obtain an appointment, even though the provider may be located within the required geographic distance), adding an appointment waiting time standard addresses this component of the emergency by providing an additional measure of actual access.

New subdivision (a) is necessary to define and clarify the terms referenced in new section 2240.15. The language of this subdivision is based on the language used by the Department of Managed Health Care in its similar regulation, at title 28, Cal. Code Regs., section 1300.67.2.2 (b). These terms were selected to maintain consistency with the nomenclature used by DMHC, consistent with Insurance Code section 10133.5(d), in order to address the emergency by making compliance easier for insurers by using the same terms.

> The definition of "appointment waiting time" at subsection (a)(1) is necessary to specify and clarify the manner in which that access indicator will be measured because it is the basis for several prescriptive time elapsed standards specified in the regulation.

The definition of "preventive care" at subsection (a)(2) is necessary to ensure clarity regarding the scope of that category of services, which is subject to prescriptive time elapsed standards in the regulation. The definition of the term is further made clear by cross-references to definitions in federal law and the Insurance Code.

The definition of "provider group" at subsection (a)(3) is necessary to ensure clarity regarding application of that term, which is referenced several times in the regulation in connection with performance standards, including standards applicable to reporting obligations.

The definition of "triage and screening" at subsection (a)(4) is necessary to ensure clarity regarding application of that term and the scope of that category of services, which is subject to prescriptive time-elapsed standards in the regulation.

The definition of "triage and screening waiting time" at subsection (a)(5) is necessary to specify and clarify the manner in which that access indicator will be measured because it is the basis for prescriptive time-elapsed standards specified in the regulation.

The definition of "urgent care" at subsection (a)(6) is necessary to ensure clarity regarding the scope of that category of services, which is subject to prescriptive time elapsed standards in the regulation.

New subdivision (b) of new section 2240.15 establishes necessary standards for insurer operations to ensure that covered persons have timely access to needed health care services. The standards selected, and the language of this subdivision, are based on the standards and language used by the Department of Managed health Care in its similar regulation, at title 28, Cal. Code Regs., section 1300.67.2.2 (c). The Department determined that adopting the appointment waiting time standards selected by DMHC will appropriately address the emergency by providing timely access, while recognizing that different acuities of medical need (such as urgent vs. non-urgent appointments) may reasonably be met by different lengths of appointment waiting time. These standards were also selected to maintain consistency with those applicable to health care service plans regulated by DMHC, consistent with Insurance Code section 10133.5(d), in order to address the emergency by making compliance easier for insurers by using consistent standards.

The standards contained in this subsection include both performance standards and prescriptive standards. The performance standards include both clinical standards and insurer and provider business/operational standards. The prescriptive standards are framed as time-elapsed standards for the time spent waiting for appointments. This mix of performance standards and prescriptive standards is designed to:

• Meet the statutory directive in Section 10133.5 to adopt standards and to consider regulations in Title 28, of the California Administrative Code of Regulations, commencing with Section 1300.67.2, which are applicable to Knox-Keene plans; and

• Ensure consistency with the legislative intent stated in Government Code section 11340.1, which requires use of performance standards unless prescriptive standards are necessary to achieve the objectives of the statute.

Subsection (b)(1) establishes the overarching and controlling clinical standard that requires the provision of services in a timely manner as appropriate for the health needs of the covered person. This provision is necessary so that the emergency may be addressed by providing appropriate access, while still giving flexibility and primacy to a treating provider's clinical judgment consistent with good professional practice, regarding the urgency of an covered person's health care needs, so that a covered person may be seen, when needed, earlier than the minimum requirements established in this section require. This subdivision accomplishes this while also ensuring that the regulation is consistent with the requirements of subsection (a) of 10123.135 and sections 10123.85**,** 10133.5, 10133.55 and 10133.56 of the Insurance Code.

Subsection (b)(2) is necessary to clarify that the time frames for procedural requirements, which are imposed on covered persons as pre-conditions to obtaining covered services, must be integrated with the time-elapsed standards established in this regulation. This is necessary to ensure that prior authorization and other procedural requirements imposed by insurers and providers are not barriers to timely appointments. For example, an insurer must complete its prior authorization process in a time frame that enables a requesting contracted provider to schedule the appointment within the time frames required by this regulation. This requirement is also necessary to comply with the legislative directive in Section 10133.5, which requires the Commissioner, in developing these regulations, to consider the regulations adopted in Title 28, of the California Administrative Code of Regulations, commencing with Section 1300.67.2, as well as consulting with the Department of Managed Health Care (DMHC) concerning regulations developed by that department pursuant to Section 1367.03 of the Health and Safety Code. This requirement is consistent with those adopted by DMHC. This requirement is also necessary to comply with the legislative directive in subsection (c) of 10133.5, which requires the Department in developing these regulations to consider the utilization review standards found in state law. The utilization review requirements found at section 10123.135 require insurers to complete prior authorization processes in a timely manner appropriate for a covered person's health condition and also establishes maximum permissible time-elapsed standards for prior authorization processes. Therefore, the earlier an appointment is needed, the earlier the prior authorization process must be completed in order to provide a timely appointment.

Subsection (b)(3) is necessary to address the emergency by clarifying that compliance with the standards established by this regulation is required when a previously scheduled appointment must be rescheduled, so that rescheduling does not become a means of re-erecting a barrier to access. For example, the provider may be called upon to perform an emergency or urgent surgery or other procedure, and his or her scheduled appointments with other patients must be rescheduled. In other instances, a provider or a covered person might have an unforeseen personal emergency or urgent situation that requires rescheduling. This provision is therefore necessary to clarify compliance expectations that insurers and contracted providers maintain processes sufficient to ensure continuity of care in rescheduling the appointments in a timely manner appropriate for the health care needs of the patients.

Subsection (b)(4) is necessary to address that aspect of the emergency that involves the lack of access to language assistance services creating a barrier to access. This subsection does so by establishing requirements regarding coordination of language assistance services with scheduled appointments. Specifically, if a limited English proficient (LEP) covered person is at a scheduled appointment, but the insurer or contracted provider who scheduled the appointment has not arranged for the provision of interpreter services at that appointment, then the services provided at the appointment are rendered inaccessible to the patient and, therefore, have not been timely provided to the patient as required by this regulation. This provision does not modify any existing requirements already established in sections 10133.8 or 10133.9 of the Insurance Code. Rather, this provision confirms the requirement set forth at subsection Title 10, California Code of Regulations section 2538.6 regarding the timely provision of language assistance services, including the coordination of interpreter services with scheduled appointments.

Subsection (b)(5) establishes: prescriptive time-elapsed standards for the time spent waiting for certain kinds of appointments with providers; and conditional exceptions to preserve the exercise of good clinical judgment by treating providers in scheduling appointments and coordinating needed health care services. These time-elapsed standards do not supersede or replace a provider's good clinical judgment. The covered person's health care needs, as determined in the good professional judgment of a qualified health care professional acting in the scope of his or her practice, is the ultimate basis for determining the relative urgency of needed services.

Subsection (b)(5)(A)-(F) establish the prescriptive time elapsed standards for urgent and non-urgent appointments with primary care physicians, specialists, mental health providers and ancillary services. As discussed above, the Commissioner has determined that adopting the appointment waiting time standards selected by DMHC will appropriately address the emergency by providing timely access, while recognizing that different acuities of medical need (such as urgent vs. non-urgent appointments) may reasonably be met by different lengths of appointment waiting time. These standards were also selected to maintain consistency with

those applicable to health care service plans regulated by DMHC, consistent with Insurance Code section 10133.5(d), in order to address the emergency by making compliance easier for insurers by using consistent standards.

Subsections (b)(5)(A) and (b)(5)(B) establish time-elapsed standards for urgent care services.

• Paragraph (A) establishes a standard of 48 hours for urgent services that do not require prior authorization, which is necessary to provide consistency with current time-elapsed standards for urgent services as applied by the Department of Health Care Serves for Medi-Cal contracts. This requirement does not create any inconsistency with the time-elapsed standards for prior authorizations established by Section 10123.135 of the Insurance Code because this requirement is applicable only to appointments for services that do not require prior authorization. Examples include but are not limited to primary care appointments and standing referrals to specialists (following the initial authorization for the standing referral). Notwithstanding this 48 hours time-elapsed standard, as explained above, the ultimate standard is based on the nature of the covered person's health care need as determined by the requesting or treating physician. This subdivision addresses the emergency by requiring access within a particular time frame. Insurers are required to assure that appointment scheduling processes are performed in a manner to ensure that urgent appointments for primary care services will be provided earlier than within 48 hours if mandated by professionally recognized standards of practice.

• Paragraph (B) establishes a time-elapsed standard of 96 hours for urgent services that require prior authorization. This timeframe is necessary to achieve consistency with the maximum permissible time-elapsed standard for prior authorization established by Section 10123.135 of the Insurance Code for urgent conditions. Notwithstanding this time-elapsed standard, as explained above, the ultimate standard is based on the nature of the covered person's health care need as determined by the requesting or treating physician., This subdivision addresses the emergency by requiring access within a particular time frame: insurers are required to ensure that prior authorization and appointment scheduling processes are performed in a manner to ensure that urgent appointments requiring prior authorization will be provided earlier than within 96 hours if that is consistent with professionally recognized standards of practice.

Subdivision (b)(5)(C) through (F) establish time-elapsed standards for non-urgent appointments for several categories of providers and services. These are based on the DMHC regulations at Title 28 of the California Administrative Code of Regulations, commencing with

Section 1300.67.2. Notwithstanding these time-elapsed standards, as explained above, the ultimate standard is the nature of the covered person's health care need as determined by the requesting or treating physician. This subdivision addresses the emergency by requiring access within a particular time frame: insurers are required to ensure that appointments for these categories of services will be provided within a specified time frame, as appropriate for the covered person's condition consistent with professionally recognized standards of practice.

Subsection (b)(5)(G) establishes a mechanism for a conditional exception to an applicable time-elapsed standard in a particular circumstance. The conditions are designed to tie the exception to the overarching clinical standard, that is, if a person qualified to triage and screen for a covered person's need for health care determines and documents that a longer waiting time will not cause detriment to the health of the covered persons. This exception is not intended to permit insurers to delay services as a matter of routine in order to accommodate business decisions, for example, in case of a foreseeable and avoidable staffing shortage or labor dispute.

- This exception permits a treating provider or screening and triaging provider to take into consideration all relevant factors that bear on the health status of an individual, including for example, pain and functional deficits.

- This exception will permit providers to make necessary adjustments to handle increased utilization during, for example, an epidemic or a natural disaster, but clarify that such an exception is only available when a qualified health care professional has assessed and documented the health needs of the covered person.

- This exception is also necessary to provide appropriate operational flexibility for providers in a manner that ensures a covered person's health needs are considered in situations where, for example, a sole practitioner family practice physician in a rural PPO network must take time off for illness or vacation and engages another physician to provide coverage. For example, existing practice involves the on-call physician receiving a patient's phone call and determining the relative urgency of the health concern or condition, and advising the patient whether to come in for an urgent appointment or whether the concerns can wait for an appointment with the patient's family practice physician.

Subsection (b)(5)(H) is necessary to clarify that advance scheduling, beyond the timeframe of the prescribed time-elapsed standards, of preventive and certain other services is not prohibited when it is consistent with good professional practice to provide advanced scheduling. Advance scheduling is customary and clinically appropriate for many conditions, and subsection (b)(5)(G confirms that it is permissible when it is done in a manner that is consistent with professionally recognized standards of practice.

Subsection (b)(5)(I) establishes a "safe harbor" provision for time-elapsed standards for primary care services. This "safe harbor" to the time-elapsed standards does not affect and, like the time-elapsed standards, is secondary to, the ultimate performance standard established at subsection (b)(1), which is based on an covered person's health care needs.

Subdivision (b)(6) is necessary to address the emergency by clarifying that the appointment waiting time standards established by this section assure access through supplementing, but not supplanting, the other network adequacy standards and criteria established by this Article. Further, this subdivision addresses the emergency by requiring that insurers have sufficient contracted providers to maintain compliance with the requirements of this section. The latter requirement is necessary in order to assure ongoing access through maintaining compliance with the appointment waiting time requirements.

Subdivision (b)(7)-(10) establishes performance standards regarding administrative functions that are directly necessary to provide timely access to health care services. A lack of provider capability to perform administrative functions necessary to deliver health care services, such as those described in Subdivision (b)(7)-(10), can detrimentally affect accessibility of services and contributes to the emergency. This provision clarifies that it is the obligation of the insurer to ensure that its contracted network has adequate capability to perform administrative functions necessary to deliver timely access to health care services.

Subdivision (b)(11) establishes requirements for insurer responsiveness to telephone inquiries from covered persons by requiring access to a knowledgeable customer service representative competent regarding the covered person's questions within 10 minutes of the covered person's initiation of the call, or within 30 minutes for a scheduled call-back call. One aspect of the emergency was that, during 2014, many covered persons had to endure long, and sometimes fruitless, waits to speak with a knowledgeable insurance representative. Obtaining answers to questions pertaining to network coverage is a perquisite to obtaining access. This new responsiveness requirement addresses this aspect of the emergency.

New subdivision (c) of new section 2240.15 is necessary to establish requirements for compliance monitoring of insurer timely access, and for effective corrective action when compliance deficiencies are identified. This is necessary to address the emergency by providing a means to monitor insurer compliance with the appointment waiting time requirements. This provision clarifies that this subdivision does not supersede or modify other requirements or standards for accessibility or for compliance monitoring contained in existing regulations. Consistent with Insurance Code section 10133.5(d), the language of this subdivision is based on the language used by the Department of Managed health Care in its similar regulation, at title 28, Cal. Code Regs., section 1300.67.2.2 (d).

The first paragraph of subdivision (c), and subdivision (c)(1), addresses the emergency by requiring that insurers have written systems, policies, and procedures in place to provide access consistent with the requirements of this section. Written procedures enhance the insurer's ability to comply with the new access requirements on a planned, rather than *ad hoc*, basis. Written procedures are necessary to address the emergency by assuring consistent application of processes to adhere to the appointment waiting time standards.

Subdivision (c)(2) is necessary to specify the required scope of monitoring mechanisms and the performance standards for each. These requirements are framed as performance standards, leaving sufficient operational flexibility so that plans can mitigate implementation costs.

• Subdivision (c)(2)(A) is necessary to clarify the minimum scope of accessibility data that insurers must track and document.

• Subdivision (c)(2)(B) requires annual covered person experience surveys and clarifies the minimum scope of inquiry that must be included in the survey. This requirement is framed as a performance standard to provide for sufficient operational flexibility to mitigate compliance costs. Many insurers already conduct surveys of covered persons. However, because covered persons lack clinical expertise, and so are not in a position to assess the clinical appropriateness of the waiting time for their appointments, and because survey return rates may be low, the Commissioner determined that insurer compliance monitoring cannot rely solely on covered person experience surveys, but must also include the provider concern survey required by subdivision (c)(2)(C).

• Subdivision (c)(2)(C) requires a survey of contracted providers to solicit their concerns regarding accessibility. This process is necessary to obtain important feedback directly from the insurer's provider network. Contracted providers are in a special position to assess and notify the insurer regarding access issues that might not otherwise come to the insurer's attention, such as long waits for specialist appointments, or for laboratory and radiology reports, or for other ancillary services, necessary to diagnose or treat their patients' health conditions.

•Subdivision (c)(2)(D) is necessary to specify the minimum frequency that an insurer must review the information available to the insurer regarding accessibility, availability and continuity of care.

Subdivision (c)(3) is necessary to address the ongoing emergency by requiring that insurers must assure access on an ongoing basis by promptly investigating and correcting compliance

deficiencies, including determining the cause of the deficiency and taking action that is sufficient to correct the deficiency. Subdivision (c)(3) also contains a requirement that insurers provide advance written notice to all contracted providers affected by a corrective action. This is necessary to ensure that insurers provide a mechanism and opportunity for affected contracted providers to inform the insurer of their concerns regarding the intended corrective action, including for example, concerns regarding continuity of care for covered persons, alternative causes for the deficiency that may not have been disclosed to or considered by the insurer in development of the corrective action, and alternative approaches to correct the compliance problems.

New subdivision (d) of new section 2240.15 is necessary address to the emergency by requiring that information regarding timely access requirements be provided to covered persons. This addresses the emergency by providing information that will empower covered persons to advocate for access, both directly with the insurer and to the Department. Consistent with Insurance Code section 10133.5(d), the language of this subdivision is based on the language used by the Department of Managed health Care in its similar regulation, at title 28, Cal. Code Regs., section 1300.67.2.2 (e).

Subdivision (d)(1) is necessary to ensure this important information is included in disclosure documents to covered persons, which will also ensure it is subject to the language assistance requirements of Section 10133.8 of the Insurance Code and section 2538.6 of Title 10. This requirement is also consistent with existing disclosure requirements in the Insurance Code and Title 10, such as section 10603 of the Insurance Code.

The requirement in subdivision (d)(2), to include in the membership card the phone number at which a covered person can access triage and screening services, is necessary to facilitate access to those services. The compliance cost and administrative burden from this requirement are nominal because insurers already issue membership cards and require that covered persons present the membership card when seeking services. Covered persons generally keep their membership card with them because they recognize the need to have the membership card available if they need to seek care unexpectedly at an emergency room. In addition, insurers already put their customer service numbers on membership cards.

New section 2240.16, Access Standards for Pediatric Vision and Oral Essential Health Benefits

As included in the discussion of amendments to section 2240.1, above, section 2240.16 provides access standards for the provision of the pediatric oral and vision essential health benefit is provided at new section 2240.16. Section 2240.16 is necessary in order to provide access standards for these specialized benefits; the particular standards selected are appointment waiting

time standards, rather than time and distance standards. This selection reflects the fact that the needs of the population receiving this benefit, and the nature of the practices of the professionals that provide pediatric oral and vision care, differ from those that apply to health benefits in general. The differences in the access standard selected reflect these differences.

Amend § 2240.4 Contracts with ~~Exclusive~~ Network Providers

Section 2240.4 is amended in order to provide that contracts with providers will provide covered persons with the benefits of the Preferred Provider or Exclusive Provider Organization contract.

The title of the section is amended to meet the clarity standard of the Administrative Procedures Act, as this section applies to all network providers, not just those in Exclusive Provider (EPO) arrangements. This correction to the title does not change the scope of this section: the section was expanded to include all network arrangements when the section was amended in 2008. However, the title was not updated at that time. Correction of the title is necessary now to meet the clarity standard of the Administrative Procedures Act, as there is currently a discrepancy between the apparent scope of the section as reflected in the title, and the actual scope of the text of the section. Changing the title addresses the emergency by making the title congruent with the scope of the section. This prevents confusion, so that insurers will know that the section, including the new provisions that address the emergency, applies to all network arrangements. If the title were left unchanged, there is a very real danger that the regulated entities would believe that the section does not apply to them, and that the emergency, to that extent, would remain unaddressed.

New subdivision (a) requires that insurers establish written policies and procedures for recruiting, credentialing, and contracting with network providers, as well as for managing their networks. Written procedures are necessary to address the emergency in order to assure consistent application of processes regarding selection and contracting with providers, and to facilitate Department oversight. In addition, this subdivision is necessary to address the emergency because, as insurers narrow or restrict their networks, or transform them to EPO arrangements, written procedures are necessary to promote adherence to the requirements of this regulation, to avoid discriminatory contracting provisions.

Subdivision (b) was formerly subdivision (a).

New subdivision (b)(6) requires that contracts with network facilities contain a provision requiring that network facilities shall determine and disclose to the insured person, prior to a non-emergency episode of care, the identity of the non-network providers who are likely to be involved in providing care, and the estimated cost of the non-network care to the insured person. One aspect of the emergency is that, increasingly, covered persons who undergo procedures in

network facilities are subject to unanticipated, undisclosed charges from non-network providers. Covered persons are third-party beneficiaries of the contracts between the insurer and its providers. Insurance Code section 10133.5(b)(4) requires that "[A]ll contracts, including contracts with providers, and other persons furnishing services, or facilities shall be fair and reasonable." The obligation that the contract be "fair and reasonable" extends to the covered person as a third-party beneficiary. The Commissioner has determined that a fair and reasonable contact would allocate to the facility, which knows who is going to practice within its walls, the responsibility to establish who will likely be involved in a patient's non-emergency episode of care. The facility is in a better position to obtain this information than the covered person, but the covered person needs this information in order to be able to make an informed decision regarding the cost of the procedure, and pursue alternatives if so desired. This contract requirement is necessary to address the occurrence of unexpected, non-network bills arising from care in a network facility that constitutes a part of the emergency.

New subdivision (c) requires that insurers provide essential community providers an equal opportunity to participate in contracts. As with proposed subdivision (h) of section 2240.1, this subdivision is necessary to address the emergency, so that narrow- restricted network design will not be used as a pretext to exclude or discourage certain particularly vulnerable populations from seeking coverage and access to care. For example, a network whose service areas included concentrations of low-income persons that excluded essential community providers who practice in the low-income areas would, by so doing, erect barriers to access by contracting with providers at a distance from the low-income community. Low-income communities are particularly sensitive to the cost of transportation; a network design that requires departure from the community and transportation to distant providers establishes a barrier to access and care, discouraging effective health management and increasing morbidity and poor health outcomes. The proposed amendment, which requires that essential community providers be provided an equal opportunity to contact, addresses the emergency by counteracting the effects of network narrowing by assuring that providers that serve low-income areas will have the opportunity to serve their patients through network arrangements.

Amend § 2240.5. Filing and Reporting Requirements.

As discussed more fully in "Statement of the Problem," above, the Department has become aware of multiple, serious complaints and reports regarding a lack of network adequacy, and resultant impediments to access. To address this aspect of the emergency, the Department needs to gather a more comprehensive data set, refreshed more frequently, in order to be able to assess access and compliance on an ongoing basis. Under the former regulation, network information was provided to the Department only when approval was sought for new policy forms, or when material changes were made to the insurer's network. As a consequence, years could pass without updated information being provided regarding network access. In light of the substantial

issues identified regarding network adequacy resulting from changes in industry practices in response to the Affordable Care Act, the current regulation does not adequately provide the information the Department needs to assure ongoing compliance, and to identify developing trends in barriers to access. Therefore, in order to address the demonstrated emergency, and to assure that health insurers promptly establish and maintain adequate medical provider networks to provide access that meets the health care needs of their policyholders, the Department needs the expanded range of information, detailed below, to assure compliance through review of the insurer networks based upon the standards set forth in these regulations. Consistent with Insurance Code section 10133.5(d), the language of this subdivision is based on the language used by the Department of Managed health Care in its similar regulation, at title 28, Cal. Code Regs., section 1300.67.2.2 (g).

As discussed in more detail below, the information required by this amendment includes:

- A network adequacy report, which demonstrates compliance with the time-and-distance access standards (this report is currently provided as a part of the existing regulation);
- A narrative report regarding compliance with mental health network requirements
- Data regarding compliance with timely access standards
- Complete information regarding the providers and facilities in the insurer's network, which the Department can then use in its analysis of the current adequacy of the network, as well as to identify developing issues in networks as they respond to market changes
- Reports of noncompliance
- Reports of complaints
- Reports regarding out-of-network use, and emergency room use. This will provide data that the Department can use to assess the effectiveness of this regulation in promoting adequate networks, as such networks obviate the need to seek care out-of-network, and reduce the use of emergency rooms as a substitute for a primary care provider.

Subdivision (a) of section 2240.5 was amended to require health insurers that utilize contracted providers to submit network adequacy report (with accompanying documents) to the Department as specified. Insurers must submit an initial network adequacy report pursuant to these emergency regulations, beginning on June 1, 2015 and annually thereafter. This requirement applies regardless of previous network adequacy filings to ensure that the provider networks adhere to these new requirements. Furthermore, this requirement applies to policies with new and current policyholders. In addition, insurers are required to submit such reports at the request of the Commissioner. This enables the Commissioner to determine that these reports are up-to-date and that insurers are complying with these regulations. Finally, consistent with the previous regulations health insurers are required to submit a network adequacy report when submitting any policy form for approval. The language was further amended to delete an obsolete reference to the Policy Approval Bureau, as health policies are now filed through SERFF (discussed below).

Subdivision (b) of section 2240.5 was added to establish how an insurer must file a network adequacy report. This amendment is necessary to address the emergency by requiring consistent reporting, so that the Department can monitor and assure compliance. Consistent with all health insurance form filings the network adequacy report must be filed with the Department's Health Policy Approval Bureau through the "California Life & Health" instance of the System for Electronic Rate and Form Filing (SERFF) of the National Association of Insurance Commissioners (NAIC). All health insurance form filings are currently submitted to the Department via SERFF, therefore this regulation ensures that network adequacy filings are submitted through the same medium consistent with current practice.

Subdivision (c) of section 2240.5 was amended to specify what must be included in the network adequacy reports. As specified below.

> This subdivision includes a new requirement which provides that insurers must now also include information broken down by county or zip code, and detailing the facilities, primary care, specialty, mental health, and behavioral health providers used by the insurer to provide services to covered persons. This subdivision was also amended to require insurers to identify the location and extent of areas of non-compliance. This detailed breakdown helps the Department make sure that the insurer has sufficient providers to meet the basic health care needs to covered persons, and also makes the Department aware of instances where an insurer has not met the requirements set forth in these regulations. The Department needs to be aware of the capacity of an insurer's network so that it knows whether insurers have the capacity to offer coverage to new persons, since the Affordable Care Act requires insurers offer coverage on a guaranteed issue basis during enrollment periods specified under federal and state law. The regulation also deleted an unnecessary reference.
>
> This subdivision also now requires an insurer to provide a description of the service areas covered by the network by zip code. Insurers are also required to specify if and how a service area has been amended since the most recently filed network adequacy report.

Subdivision (d) was added to specify the documents which must be included in the network adequacy report.

> Subdivision (d) (1)-(3) of section 2240.5 renumbers language previously found in this section. In addition, subdivision (d)(3) deletes a reference that provided that rates and rate schedules need not be filed with this report, since if a carrier is submitting a network adequacy report as a part of a form review rate submission is required by state law.

Subdivision (d)(4)-(5) are added to require insurers to provide copies of written policies and procedures manage the insurer's network, which relate recruiting, credentialing, accrediting and contracting with network providers. Insurers must also include the selection and tiering standards required by Section 2240.1(h), as well as the mental health access report required by section 2240.1(c)(5)(C). All this information is necessary for the Department to fully analyze and ensure that insurers are complying with these regulations.

Former subdivisions (b) and (c). Subdivision (b) was deleted it as includes outdated language relating to the initial filing of network adequacy reports in 2008. Subdivision (c) was deleted as it previously allowed insurers to file an affidavit or attestation that the network for a new product was substantially the same as the network for a previously filed product. Given the strains and rapid changes now being seen in networks, as companies adapt to new market forces, the Department has determined that the former approach is insufficient to assure access to care. In order to address the emergency, it is necessary that the Department receive additional, more detailed data more frequently in order to assure access through monitoring of insurer compliance.

Subdivision (d)(6) of section 2240.5 was added to require insurers to submit as a part of the insurer's timely access policies and procedure, any alternative to or time-elapsed standards previously approved by the Department. This will enable the Department to review previously approved standards in the context of the new network filing.

Subdivision (d)(7) of section 2240.5 was added to require insurers to submit to the Department documentation regarding the insurer's compliance with time elapsed standards set forth in Section 2240.1(c). This data may be acquired through a statistically reliable sampling methodology, such as provider and insured surveys.

Subdivision (d)(8) of section 2240.5 was added to require insurers to submit documentation to the Department relating to noncompliance with this article. The report shall identify incidents of noncompliance that resulted in substantial harm to a covered person, as well as any patterns of noncompliance. The report must also include information relating the insurer's response, investigations, determinations and any corrective actions taken.

Subdivision (d)(9) of section 2240.5 was added to require insurers to submit documents describing the implementation and use of triage, telemedicine and health information technology to provide timely access to care. This allows insurers to demonstrate alternative means of providing adequate access, as appropriate.

Subdivision (d)(10) of section 2240.5 was added to require insurer to submit documentation of the most recent annual covered person and provider surveys required

by this article. The insurer must also compare that data with prior survey's and include a discussion of changes.

Subdivision (d)(11) of section 2240.5 was added to require insurers to submit documentation of the claim data relating to the use of out-of-network services.

Subdivision (d)(12) of section 2240.5 was added to require insurers to submit data relating to the extent emergency room services were used by covered persons during the reporting period. Similarly, subdivision (d)(13) requires submission of the transplant center report required by subdivision (f) of section2240.1.

Subdivision (d)(14) requires detailed information regarding enrollment in the insurer's products, and a complete list of the insurer's providers and facilities, including specialty qualifications (using the designations used by the recognized national standards board, the American Board of Medical Specialties), by California license number and the unique national identifying number issued by the federal government (the National Provider Identification Number)[33]. Subdivision (e) requires that this information be provided with the network adequacy report, until such time as the Department establishes a web portal for the submission of the data specified in subdivision (d)(14). The language in subdivisions (d)(14) and (e) is identical to the language used by the Department of Managed Health Care in title 28, Cal. Code Regs., section 1300.67.2.2(g)(2)(G), except for the internal section references and the name of the "network adequacy report."

Subdivision (f) of section 2240.5 was previously subdivision (d) of this section.

Subdivision (g) of section 2240.5 (previously 2240.5(e)) was amended to require insurers to annually submit a network adequacy report through SERFF no later than March 31 on complaints and issues relating to contract providers that insurers have received in the previous calendar year. This amendment is necessary to address the emergency because complaints regarding network adequacy are an important means by which to assess the success of this regulation in resolving the emergency. Accordingly, this amended regulation provides for a more robust data set regarding network complaints. The report will now include summaries of receipt and resolutions of complaints received from providers and covered persons. This must be done by type of service, as specified. In addition, the summary shall be broken down by: the number of complaints in the last year, the identity of complaint, description of complaint, whether the complaint is resolved, the date the complaint was received, how long it took to

[33] The National Provider Information number is the national standard unique health identifier for health care providers assigned by the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System, pursuant to title 45, Code of Federal Regulations, Part 162, Subpart D (§§ 162.402-162.414).

resolve the complaint, a description of why the complaint was unresolved, and a description of any applicable resolution.

Subdivision (i) of section 2240.5 was added to include a provision wherein the Commissioner may audit compliance with this article through requests for additional information including background information, and surveys, and through conducting direct surveys of providers and covered persons. This new subdivision is necessary to address the emergency so that the Commissioner can evaluate and monitor the accuracy of insurer compliance reports, as well as directly evaluating the degree to which the regulation has resolved the emergency.

Subdivision (j) of section 2240.5 was formerly subdivision (f).

Adopt new section 2240.6. Notice and Information to Covered Persons

As discussed more fully in "Statement of the Problem," above, the Department has become aware of multiple, and growing, issues regarding inaccurate provider directories. Inaccurate provider directories are directly related to the emergency circumstances justifying this regulation, as an inaccurate directory either delays, or acts as a barrier to care, with potential adverse health consequences, or results in unexpected charges (through, for example, obtaining care from a provider incorrectly listed as in-network, but later discovering that the provider is no longer in network, resulting in unexpected out-of-network fees). For these reasons, the following specific requirements regarding consumer disclosure are added to the regulation in order to remove this barrier to access to these needed health care services.

Subdivision (a) of section 2240.6 relates to the scope of 2240.6. This subdivision specifies that all provider directories must be updated pursuant to this section and clarifies that provider directories must be made available to individuals with disabilities and/or limited English proficiencies. The requirement that the directories be updated is necessary to ensure that covered persons can access up-to-date directories, so that they are fully informed when making decisions about medical services. Covered persons rely upon provider directories to make choices about their health care services and to ensure that these services are in-network. A covered person could be subject to unanticipated medical costs, if they rely upon a provider directory that is not up-to-date. Furthermore, this subdivision requires provider directories to be offered to individuals with limited English proficiencies and/or disabilities. Singling these individuals out by not providing them access to provider directories would be discriminatory and erect barriers to care. This language ensures that there are no misinterpretations by insurers, so that all covered persons are treated equally when these regulations are implemented.

Subdivision (b) of section 2240.6 specifies that insurers must state in consumer coverage materials where the provider directory may be found and requires insurers to post an up an up-to-

date provider directory on their website. For the provider directory to be useful, covered persons must know where the directory may be found and the directory must be readily accessible. Therefore, this language is necessary to make sure insurers actually provide covered persons with notice of the location of the provider directory. Furthermore, by requiring insurers to post the provider directory on their website, it ensures covered persons know where to find the most up-to-date provider directory when making choices relating to health insurance coverage providers. Furthermore, this subdivision specifies that the directory must be updated on a weekly basis. If a covered person relies upon an out-of-date directory when making choices about their health care services, that person may see a provider who is no longer in-network and incur out-of-network costs. Therefore, this requirement that insurers update their online provider network on a weekly basis is a necessary consumer protection. Finally, this subdivision requires insurers post this information on their public website (without a password or policy number), which will enable consumers shopping for health insurance to determine if their provider is covered by a specific insurer's network. Accuracy and accessibility of provider directories are necessary elements in addressing the aspect of the emergency that arises from inaccurate provider directories, and are crucial to shielding covered persons from unexpected out-of-network costs.

Subdivision (c) of section 2240.6 specifies how insurers must categorize the information in the provider directory (as set forth in subdivision (g)). This subdivision also requires insurers to demonstrate, at the request of the Department, that the provider directory is accurate. Breaking down the provider directory into the categories specified in (g) provides covered persons with a provider directory that is both meaningful and useful, as it provides information that the average covered person would want to know when choosing a provider. Requiring insurers to demonstrate the accuracy of the provider directory also is an additional means by which the Department can ensure that these directories are up-to-date, and therefore address this aspect of the emergency.

Subdivision (d) of section 2240.6 requires insurers to inform covered persons about the availability of a paper copy of the provider network. The paper copy must be printed annually and updated quarterly. However, the quarterly updates may be provided as an insert or addendum to the annual copy. This language is necessary, since not all covered persons can afford or have access to the internet. An online-only provider directory is not beneficial to such individuals, and would not afford these persons with the consumer protections found in these regulations. Therefore for this regulation to provide meaningful access to all covered persons, access to a paper directory is necessary.

Subdivision (e) of section 2240.6 requires insurers with more than one provider network to make clear, to a reasonable person, the network applicable to each of the insurer's policies. Currently multiple insurers have different networks which apply to different policies. Covered persons

need to know the network applicable to their policy. Failure to specify the provider network that applies to a specific policy would mean that covered person could rely upon the incorrect provider network when making provider decisions and accrue unanticipated medical costs. Confusion as to the directory applicable to a consumer's coverage has been one of the directory issues underlying this emergency; this provision addresses that concern.

Subdivision (f) of section 2240.6 requires insurers to inform a covered person about the availability of translations and interpreter services, consistent with Insurance Code section 10133.8. This subdivision is necessary to avoid any confusion regarding the applicability of Insurance Code section 10133.8 to these directories. Furthermore, for purposes of consumer protection and education is it necessary for covered persons with limited English proficiency to understand the provider directory, so that they can communicate with their doctors and receive access to the medical attention they need.

Subdivision (g) of section 2240.6 requires insurers to provide information about each provider which includes: the name of the provider, the specialty area or areas of the provider, whether the provider is currently accepting new patients, whether the provider may be accessed without referral, the location(s), including address, and contact information for the provider, the gender of the provider, languages spoken by the provider, languages spoken by office staff, a list of network facilities where the provider has admitting privileges, whether the provider is a primary care physician (PCP), and whether the office is ADA accessible. The information specified in these categories is necessary for covered persons to make informed decisions about their current and potential medical providers. Providing this information allows covered persons to determine important information such as: how far the provider is from a person's home or work, whether a covered person can talk to their provider in a language other than English, and for covered persons who need an ADA accessible building, whether they can access their provider's office. Therefore, all of this information is necessary for covered persons to access their health insurance coverage, to better educate themselves, and to choose the appropriate provider. This information is crucial to address the access issues identified in this "Express Finding of Emergency."

Subdivision (h) of section 2240.6 requires online and printed provider directories inform covered persons about the timeframe specified in these regulations. If covered persons are unaware that insurers must provide services within specific timelines, they may not know that their insurer is in violation state law. Consumer complaints are one way the Department is made aware of insurer violations of the law. Therefore, notifying covered persons about waiting times provides consumers about education relating to their coverage, allowing them to notify the Department if an insurer fails to comply with the timelines specified in these regulations. Therefore, this subdivision provides another way for the Department to be notified about insurer violations of

these regulations, providing a necessary means for the Department to assess the degree to which this regulation addresses the emergency.

Subdivision (i) of section 2240.6 requires insurers to identify: providers who employ multilingual staff, providers who employ multilingual providers, and multi-lingual contracting providers based upon language capability disclosure forms. This information is then provided to covered persons in the provider directory. This subdivision allows covered persons, who speak languages other than English, to know whether they will be able to speak directly with their provider or their provider's staff when receiving medical attention. The ability of a covered person to understand their doctor is essential in making medical decisions, so this information is vitally important anyone making medical decisions. This subdivision allows all covered persons to access this information. This provision is necessary to address the emergency, as language access issues can otherwise present serious impediments to the ability to access care.

Subdivision (j) of section 2240.6 requires insurers to notify patients, who have been seen by a provider within the last year, if their provider is leaving the insurer's network. This subdivision applies regardless of the provider's reason for leaving the network. This language is necessary to ensure covered persons know that any future services provided by this provider are out-of-network. Furthermore, this subdivision notifies consumers with future appointments of the need to find another provider if services are to be paid at an in-network rate. Finally, this subdivision makes covered persons, who fall under the continuity of care provisions of the Insurance Code, aware of the need to access those rights. This subdivision is necessary to address the emergency because, without this information, covered persons would be exposed to unanticipated out-of-network expenses, with the resultant adverse financial consequences detailed in the "Express Finding of Emergency."

New section 2240.7: Discretionary Waiver of Network Access Standards

Section 2240.17 establishes standards whereby the Insurance Commissioner will review requests from insurers for a discretionary waiver to the requirements of these regulations when an insurer is unable to meet the network adequacy standards, allow an alternative access delivery system to be offered by the insurer, and sets forth the process by which the Commissioner shall review the alternative access delivery system and grant the waiver. In order to assure network access is maintained, this section requires an annual application for such a waiver and sets forth four bases upon which the waiver may be granted.

The current regulations, under section 2240.1(c)(7), allow for insurers to apply for a discretionary waiver "if an insurer is unable to meet the network access standard(s) required by this section due to absence of practicing providers located within sufficient geographic proximity of the insurer's covered persons," but do not specify what the insurer must do to

obtain a waiver from the Commissioner, any requirements that need to be met for the waiver, provide for any alternatives for accessibility of provider and cost standards for the protection of covered persons based upon the insurance policies or contracts, or establish standards for the Commissioner to exercise his or her discretion to allow a waiver from the established network adequacy standards and allow a legally sufficient alternative access delivery system. The purpose of this new section is to correct these issues.

Subdivision (c) of section 10133.5 of the Insurance Code requires the Commissioner to consider requirements under other state programs or laws and the standards adopted by other states. Washington State has developed a comprehensive set of statutes and regulations regarding network adequacy and allowing waivers to its own network adequacy standards that are the most extensive standards in the country. This new regulation section reflects many of the standards adopted by Washington State set forth in Washington Administrative Code, Chapter 284-43, Subchapter B, Sections 200 to 201.

This new section is necessary to establish the rules by which insurers will create acceptable alternative network delivery systems when the established requirements cannot be met due to circumstances beyond the insurer's control, as established by these regulations, and still allow for delivery of adequate, sufficient, and timely medical benefits to covered persons according to the policy or contract pursuant to Insurance Code section 10133.5. These standards set forth and allow for a process by which the Commissioner will act under specified circumstances to allow a waiver from these requirements and approve an alternative access delivery system while still effectuating the purpose of Insurance Code Section 10133.5, ensuring access to needed health care services.

d. SUMMARY OF EXISTING LAWS AND REGULATIONS

The Department of Managed Health Care has promulgated regulations regarding network adequacy at 28 California Code of Regulations sections 1200.51(d), Item H, 1300.61.1, 1300.67.2, 1200.67.2.1, and 1300.67.2.2. The proposed regulation utilizes portions of section 1300.67.2.2.

The California Health Benefit Exchange (Covered California) promulgated regulations which, at title 45 Cal. Code Regs § 6410 defined "Essential Community Providers" by referencing federal regulations at 45 C.F.R. 156.235. This same federal definition is referenced in the proposed regulation at proposed section 2240(e).

The proposed regulation is not inconsistent or incompatible with existing California regulations or statutes.

e. COMPARABLE FEDERAL LAW AND REGULATIONS

There is no comparable federal law or regulations regarding specific performance requirements for provider networks in all health insurance markets. There are federal regulations that discuss networks in limited settings, but they do not address specific network or reporting requirements. For example, federal regulations require that Exchanges, such as the California Health Benefit Exchange (Covered California), must ensure that provider networks of plans offered through Exchanges must be "sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." (45 C.F.R.§ 156.230, referenced in 45 CFR § 155.1050. Also, 42 USC 300gg-1(c), 42 USC 300gg-41). The proposed emergency regulation is consistent with these federal network regulations.

Federal regulations at 45 C.F.R. 156.235 define "Essential Community Providers." This definition is referenced in the proposed regulation at proposed section 2240(e).

The proposed regulation is not inconsistent or incompatible, nor does it differ substantially from, existing federal regulations or statutes.

f. OTHER AGENCY-SPECIFIC STATUTORY REQUIREMENTS

The Department has complied with Insurance Code section 10133.5(c)(d), which provides:

> (c) In developing standards under subdivision (a), the department shall also consider requirements under federal law; requirements under other state programs and law, including utilization review; and standards adopted by other states, national accrediting organizations and professional associations. The department shall further consider the accessability *(sic)* to provider services in rural areas.
>
> (d) In designing the regulations the commissioner shall consider the regulations in Title 28, of the California Administrative Code of Regulations, commencing with Section 1300.67.2, which are applicable to Knox-Keene plans, and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. The department shall consult with the Department of Managed Health Care concerning regulations developed by that department pursuant to Section

1367.03 of the Health and Safety Code and shall seek public input from a wide range of interested parties.

In designing the revision to regulations, the Commissioner considered the following regulations applicable to Knox-Keene plans regulated by the Department of Managed Health Care (DMHC):

28 California Code of Regulations section 1200.51(d), Item H, regarding the geographic service area requirements set forth in the DMHC license application form.

28 California Code of Regulations section 1300.61.1, regarding availability of primary care physicians as a component of continuity of care.

28 California Code of Regulations section 1300.67.2, regarding accessibility of services, including facility location, hours of operation, availability of emergency health care services, ratios of enrollees to staff, including administrative and supporting staff, accessibility to medical specialists, systems regarding monitoring and evaluating accessibility of care, and other factors.

28 California Code of Regulations section 1200.67.2.1, regarding geographic accessibility standards, including application of Item H of 10 CCR 1200.51(d), above, and factors used in evaluation of accessibility standards proposed by health plans.

28 California Code of Regulations section 1300.67.2.2, regarding the use of appointment waiting time as a means to assess timely access to non-emergency health care services.

Staff of the Department of Insurance met with staff of the Department of Managed Health Care regarding the existing DMHC network adequacy regulation in the context of this revision of the Department of Insurance regulation, particularly regarding title 28, Cal. Code Regs. Section 1300.67.2.2, which was adopted in 2010, pertaining to the use of appointment waiting time as a means of assuring access to health care services. Department staff also considered the network adequacy regulation recently adopted by the State of Washington (Washington Administrative Code 284-43-200 et seq. as amended effective 5/26/14) and network adequacy regulations of the federal Medicare Advantage program. The Department is also California's representative on the National Association of Insurance Commissioners Network Adequacy Model Review Subgroup revising the NAIC Model Network Adequacy Regulation, and has considered information obtained during meetings of the Subgroup, and from comments submitted to the Subgroup, during the development of these regulation amendments. The Department held public meetings on December 10, 2013 and June 30, 2014 to receive public comments regarding proposed drafts of amendments to the Department's network access regulation, and received and considered comments from a wide range of interested parties, including the a national health quality

accrediting organization. In addition, the Department considered comments regarding accessibility in rural areas, particularly rural areas affected by winter road closures.

g. INCORPORATION BY REFERENCE

The definition of "Essential Community Providers" at proposed section 2240(e) incorporates by reference the definition of that term in federal regulations at 45 C.F.R. 156.235, published on March 27, 2012.

h. CONSISTENCY OR COMPATIBLILITY WITH EXISTING STATE REGULATIONS

The Department has conducted an evaluation of existing law, including a review of the existing regulations of the Department, DMHC, and the California Health Benefit Exchange, and has determined that the proposed regulations are not inconsistent or incompatible with any existing state regulations.

4) STATEMENT REGARDING COMPLIANCE WITH NOTICE REQUIREMENTS (GOV. CODE § 11346.1(A)(2), INS. CODE 12921.7)

In compliance with Government Code section 11346.1 and Insurance Code section 12921.7, the Commissioner has mailed this notice to each person, group, or association who has previously files a request for notice of regulatory actions with the Commissioner.

Pursuant to Insurance Code Section 12921.7, this notice includes:

1) A description of the problem and the necessity for the regulation.
2) A description of the justification for adoption of the regulation as an emergency regulation
3) A copy of the text of the proposed emergency regulation

5) LOCAL MANDATE DETERMINATION

The proposed regulations do not impose a mandate on local agencies or school districts. There are no costs to local agencies or school districts for which Part 7 (commencing with Section 17500) of Division 4 of the Government Code would require reimbursement.

6) FISCAL IMPACT ESTIMATE

The Commissioner has determined that the proposed regulations will result in no cost or savings to any state agency and no cost to any local agency or school district that is required to

be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code. The proposed regulations do not impose other nondiscretionary cost or savings on local agencies, and result in no cost or savings in federal funding to the State.

These regulations do not have a fiscal impact on any State agency or program, and does not affect any federally funded agency or program.

7) STUDIES AND REPORTS

The Department has relied on the following:

1. Appleby, Julie. *Anthem Blue Cross Sued Over Covered California Doctor Networks* (July 9, 2014). The California Report: State of Health. http://blogs.kqed.org/stateofhealth/2014/07/09/lawsuit-anthem-blue-cross-committed-fraudulent-enrollment-practices/

2. Appleby, Julia. *Consumer Group Sues 2 More Calif. Plans Over Narrow Networks.* (September 25, 2014). Kaiser Health News. http://kaiserhealthnews.org/news/consumer-group-sues-2-more-calif-plans-over-narrow-networks/

3. Appleby, Julie. *'Narrow Networks' Frustrate Consumers in California and Nationwide* (July 28, 2014). The California Report: State of Health. http://blogs.kqed.org/stateofhealth/2014/07/28/narrow-networks-frustrate-consumers-in-california-and-nationwide/

4. Barber, Christine, et al. *Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market.* (November, 2014) National Association of Insurance Commissioners. http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf

5. Bartolone, Pauline. *Calif. Health Insurers Restrict Doctor Choice to Lower Cost.* (December 1. 2013). Capital Public Radio. http://www.capradio.org/articles/2013/12/01/calif-health-insurers-restrict-doctor-choice-to-lower-costs/

6. Bartolone, Pauline. *California Border Residents Grapple with Out-of-State Health Insurance Restrictions* (December 16, 2014), Capitol Public Radio, http://www.capradio.org/articles/2014/12/16/california-border-residents-grapple-with-out-of-state-health-insurance-restrictions/

7. Bernard, Tara, *Out of Network, Not by Choice, and facing Huge Health Bills* New York Times (October 18, 2013) http://www.nytimes.com/2013/10/19/your-money/out-of-network-not-by-choice-and-facing-huge-health-bills.html?pagewanted=all&_r=1&

8. Bureau of Labor Statistics: Consumer Price Index - All Urban Consumers: Item: Medical Care Series ID: CUUR0000SAM, Accessed August 6, 2014, http://data.bls.gov

9. Crane, Kristin. *Socked with an Out-of-Network Medical Bill?* (August 13, 2014) US News & World Report, http://health.usnews.com/health-news/patient-advice/articles/2014/08/13/socked-with-an-out-of-network-medical-bill

10. Corlette, S., Volk, J., Berenson, R. & Feder J. *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*, (May 2014). The Center on Health Insurance Reforms, Georgetown University/The Urban Institute, p. 2. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413643.

11. Dembosky, April. *Adequacy of Doctor Networks Key Issue for Covered California*. (May 22, 2014). The California Report: State of Health. http://blogs.kqed.org/stateofhealth/2014/05/22/adequacy-of-doctor-networks-key-issue-for-covered-california-narrow-networks/

12. Dranove, David & Millenson, Michael, L. *Medical Bankruptcy: Myth Versus Fact*, published online February 28, 2006; 10.1377/hlthaff.25.w74, Health Affairs, 25, no.2 (2006):w74-w83, http://content.healthaffairs.org/content/25/2/w74.full.html

13. *Final Report, Non-Routine Survey of Anthem Blue Cross, A Full Service Health Plan*. (November 18, 2014) Department of Managed Health Care. p. 3. http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf

14. *Final Report, Non-Routine Survey of Blue Shield of California, A Full Service Health Plan*. (November 18, 2014) Department of Managed Health Care. p. 3. http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fsnr111814.pdf

15. Fowler-Brown, Angela, et al. *Risk of Cardiovascular Events and Death – Does Insurance Matter?* (February 16, 2007). Journal of General Internal Medicine.

16. Gorn, David. *Health Net Sued Over Network Adequacy*. (December 12, 2014) CaliforniaHealthLine, http://www.californiahealthline.org/capitol-desk/2014/12/health-net-sued-over-network-adequacy , see also http://www.californiahealthline.org/~/media/Files/2014/PDFs/LaRue%20Complaint.ashx

17. Ng, Derek K., et al. *Insurance Status, Not Race, is Associated with Mortality after an Acute Cardiovascular Event in Maryland* (July 21, 2012). Journal of General Internal Medicine.

18. Norris, Frank H. Jr. *Increased Risk of Death among Uninsured Neonates* (August 2013). Health Services Research 48:4.

19. Parikh, Alexander A., et al. *The Effect of Health Insurance on the Treatment and Outcomes of Patients with Colorectal Cancer* (2014). Journal of Surgical Oncology, pp. 110.

20. Parikh, Puja B., et al. *Association of Health Insurance Status with Presentation and Outcomes of Coronary Artery Disease among Nonelderly Adults Undergoing Percutaneous Coronary Intervention* (September, 2011). American Heart Journal.

21. Pizer, Steven D. & Prentice, Julia C. *Delayed Access to Health Care and Mortality* (2006), Health Research and Educational Trust. [DOI: 10.1111/j.1475-6773.2006.00626.x].

22. Pogue, Stacey. *Surprise Medical Bills Take Advantage of Texans: Little-known practice creates a "second emergency" for ER patients* (September 15, 2014). Center for Public Policy Priorities, pp. 2-5. http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf

23. *QHP New Entrant Certification Application for Plan Year 2016*, (December 22, 2014). Covered California. Slide 5, "Draft Proposed Recertification/Certification Timeline for Plan Year 2016" http://hbex.coveredca.com/stakeholders/plan-management/PDFs/12-22-14%20QHP%20New%20Entrant%20Draft%20Application%20Review%20Webinar%20Presentation.pdf.

24. Rosenthal, Elisabeth. *After Surgery, Surprise $117,000 Medical Bill From Doctor He Didn't Know.* (Sept. 20, 2014). New York Times. http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html

25. Rosenthal, Elisabeth. *Costs Can Go Up Fast when E.R. Is In Network But The Doctors Are Not.* (September 28, 2014). New York Times. http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html?_r=0

26. *Straightforward Contracting for a Stronger Health Care System*, (April 28, 2014). California Medical Association. http://www.cmanet.org/files/assets/news/2014/05/all-products-survey-final-043014.pdf

27. Terhune, Chad. *California Probes Obamacare Doctor Networks at Anthem and Blue Shield*. (June 20, 2014). Los Angeles Times. http://www.latimes.com/business/healthcare/la-fi-state-investigating-obamacare-networks-20140619-story.html

28. Terhune, Chad. *Insurers Limiting Doctors, Hospitals in Health Insurance Market*. (September 14, 2013) Los Angeles Times. http://articles.latimes.com/2013/sep/14/business/la-fi-insure-doctor-networks-20130915

29. US Courts: Report F-5A. U.S. Bankruptcy Courts Business and Nonbusiness Bankruptcy County Cases Commenced, by Chapter of the Bankruptcy Code, During the 12- Month Period Ending December 31, 2013, http://www.uscourts.gov/Statistics/BankruptcyStatistics/2013-bankruptcy-filings.aspx

30. Weissmann, Jordan. *Why Can't States Do More to Protect Patients from Surprise Medical Bills?* Slate (October, 2014) http://www.slate.com/articles/business/moneybox/2014/10/surprise_out_of_network_hospital_bills_why_it_s_so_hard_for_states_to_protect.html.

31. Wilper, Andrew P., Woolhandler, Steffie, et al. *Health Insurance and Mortality in US Adults* (December 2009) American Journal of Public Health.

8) Appendix A: Description of Calculation of Mortality Risk Justifying Emergency

Definition of Symbols:

X	Estimated under-65 population of California in 2015 excluding Medi-Cal
p	Proportion of 'X' with Health Coverage
q	Percentage of insured Californians in 2015 that will benefit from **CDI's proposed network regulation**
r	Percentage of insured Californians considered "in-network" ***before adoption*** **of proposed regulation**
s	Percentage of insured Californians considered "in-network" ***after adoption*** **of proposed regulation**

ω	Anticipated mortality rate of Californians in 2015, ***before adoption*** **of proposed regulation**
α	Relative mortality (Odds Ratio) of uninsured to insured *before* ***adoption*** **of proposed regulation**
β	Relative mortality (Odds Ratio) of insureds **using out of network services** to insureds **using network services**
$\omega_{i(pre)}$	Mortality rate of **insured** Californians in 2015, ***before adoption*** **of proposed regulation**
$\omega_{i(post)}$	Mortality rate of **insured** Californians in 2015, **after *adoption* of proposed regulation**
ω_u	Mortality rate of **uninsured** Californians in 2015
N	Number of lives that may be saved in 2015 if the proposed regulation is adopted

Deriving the Formula

Following the adoption of the proposed regulation we anticipate, N, the number of lives saved to be:

$$\mathbf{N = X \times p \times q \times (\omega_{i(pre)} - \omega_{i(post)}) = X \times p \times q \times \omega \times (s - r) \times (\beta - 1) / [(p + \alpha \times (1 - p)) \times (r + \beta \times (1 - r))].}$$

Derivation of the formula for the number of lives saved:

From the definition of odds ratio we have:

$$\text{Odds Ratio: } \alpha = \omega_u / \omega_{i(pre)}. \qquad (1)$$

Also, the overall mortality rate of population is a weighted average of the mortality rate of insured and uninsured. Therefore, we can write:

$$\omega = \omega_{i(pre)} \times p + \omega_u \times (1 - p). \quad (2)$$

Substituting $(\omega_{i(pre)} \times \alpha)$ for ω_u from equation (1) above, we have:

$$\omega = \omega_{i(pre)} \times p + \omega_u \times (1 - p)$$

$$= \omega_{i(pre)} \times p + \omega_{i(pre)} \times \alpha \times (1 - p) = \omega_{i(pre)} \times (p + \alpha \times (1 - p)). \quad (3)$$

Solving equation (3) above for $\omega_{i(pre)}$, we have:

$$\omega_{i(pre)} = \omega / (p + \alpha \times (1 - p)). \quad (4)$$

Next, let:

ω_{ii} Mortality rate of **insured** Californians in 2015 who receive all their services in network

ω_{io} Mortality rate of **insured** Californians in 2015 who receive all their services out of network

Using the above assumption, we can write:

$$\omega_{i(pre)} = \omega_{ii} \times r + \omega_{io} \times (1 - r), \quad (5)$$

Here r represents the percentage of insured Californians receiving services in network **before the proposed regulation.**

And, from the definition of β, the odds ratio of insureds receiving out-of- network services to insureds receiving services in network, we can write:

$$\omega_{io} / \omega_{ii} = \beta. \quad (6)$$

Substituting $(\omega_{ii} \times \beta)$ for ω_{io} from equation (6) above we get:

$$\omega_{i(pre)} = \omega_{ii} \times r + (\omega_{ii} \times \beta) \times (1 - r) = \omega_{ii} \times (r + \beta \times (1 - r)). \quad (7)$$

Solving equation (7) for ω_{ii}, we get:

$$\omega_{ii} = \omega_{i(pre)} / (r + \beta \times (1 - r)). \quad (8)$$

And, from equation (6) and (8) we get:

$$\omega_{io} = \omega_{ii} \times \beta = \beta \times \omega_{i(pre)} / (r + \beta \times (1 - r)). \quad (9)$$

After the proposed regulation is adopted, the percentage of claims originating in network will increase from r to s, and hence the morbidity rate of insureds ***after the adoption*** **of proposed regulation** will be:

$$\omega_{i(post)} = \omega_{ii} \times s + \omega_{io} \times (1 - s). \quad (10)$$

Substituting values of ω_{ii} and ω_{io}, from equations (8) and (9) into equation (10), we get:

$$\omega_{i(post)} = (\omega_{i(pre)} / (r + \beta \times (1 - r))) \times s + (\beta \times \omega_{i(pre)} / (r + \beta \times (1 - r))) \times (1 - s)$$

After some simplification, we get:

$$\omega_{i(post)} = \omega_{i(pre)} \times (s + \beta \times (1 - s)) / (r + \beta \times (1 - r)). \quad (11)$$

And, the number of lives saved can be calculated using the following formula:

$$N = X \times p \times q \times (\omega_{i(pre)} - \omega_{i(post)}).$$

Substituting for $\omega_{i(pre)}$ and $\omega_{i(post)}$ from equation (4) and (11) we get:

$$\mathbf{N = X \times p \times q \times (\omega_{i(pre)} - \omega_{i(post)}) = X \times p \times q \times \omega \times (s-r) \times (\beta-1) / [(p+\alpha \times (1-p)) \times (r+\beta \times (1-r))]}$$

Numerical Estimate of Lives Saved:

Using the foregoing model, CDI's Health Actuarial Office (HAO) calculated a total estimate of lives saved annually due to the proposed regulation at between 17 and 42 lives. The midpoint for illustration purposes is 26. The following values and assumptions were used in this model:

X, Estimated under-65 population of California in 2015 excluding Medi-Cal: 24.7 million. The California Department of Finance projects a California population for 2015 of 38.8 million.[34] Medi-Cal and over 65 populations were then excluded using population estimates by the California Health Benefits Review Program (CHBRP) in a Brief titled "Estimates of Sources of Health Insurance in 2014"[35]

p, Proportion of X with Health Coverage: 88.5%. This estimate is based on data from a Brief published by the CHBRP "Estimates of Sources of Health Insurance in 2014".

q, Proportion of (p*X) subject to proposed regulation: 9.8%. This estimate is based on data from a Brief published by the CHBRP "Estimates of Sources of Health Insurance in 2014". This

[34] State of California, Department of Finance, Report P-1: State and County Total Population Projections, 2010-2060. Sacramento, California, January 2013. Accessed December 4, 2014. http://www.dof.ca.gov/research/demographic/reports/projections/P-1/documents/P-1_County_CAProj_2010-2060_5-Year.xls

[35] Estimates of Sources of Health Insurance in 2014, California Health Benefits Review Program, April 11, 2014 http://www.chbrp.org/other_publications/docs/Estimates_for_Sources_2015_Final_041114.pdf

represents the proportion of CDI regulated business to all people with health coverage in the under 65 California population excluding Medi-Cal.

r, Percentage of insured Californians designated as "In Network" *before adoption* of proposed regulation: Although in fact many individuals do receive services both in and out of network, the model makes the simplifying assumption that each member receives all his or her services in network or out of network but not both. The model designates members as having in- or out-of-network status in the same proportion as dollars are billed in or out of network, i.e. "r" and "1-r". "r" is therefore assigned the value of **87.2%,** which is the weighted average of the pre regulation participation assumptions used in table 3 of the SRIA.

s, Percentage of insured Californians designated as "In Network" *after adoption* of proposed regulation: For this value we use **89.8%**, which is the weighted average of the post regulation participation assumptions used in table 3 of the SRIA.

α, ratio of uninsured mortality to insured mortality: 1.4 is the hazard ratio found in the American Journal of Public Health Article published in 2009.[36]

β, The estimated mortality of individuals designated as "out of network" relative to the mortality of individuals designated as "in network": 1.30.

Derivation of the estimate: The studies cited in this Appendix suggest that an individual's expected mortality is related to access to care, which in turn is related to network status. Out-of-network members are found to have inferior access with respect to waiting times, distance traveled and out-of-pocket costs, all of which constitute barriers to care.

Waiting time alone can constitute a significant barrier to care and can influence mortality, as shown in the VA study where those patients with waiting times of over 30 days had mortality 21% higher than those with waiting times less than 30 days **(**β of 1.21).

When estimating β, HAO took the results of the VA study into consideration as well as the impact of distance and travel time and financial barriers. Taking all of these factors into consideration, HAO conservatively estimated 1.3 for the value of Beta-higher than what was reported in the VA study because of the inferior access for out-of-network members vis-à-vis veterans, as mentioned above.

To test the sensitivity of this parameter HAO tested the model using a low β of 1.2 and a high value of 1.5. Using the range of βs, the estimate of lives saved ranges from 17 to 42.
Again, the midpoint for illustration purposes is 26 (as summarized in the table below).

[36] Health Insurance and Mortality in US Adults. Andrew P. Wilper, Steffie Woolhandler, Karen E. Lasser, Danny McCormick, David H. Bor, and David U. Himmelstein. American Journal of Public Health December 2009

ω, Estimated mortality rate for X, under-65 population of California in 2015 excluding Medi-Cal: 0.175%. Overall California and National mortality rates were taken from a recent National Center for Health Statistics issue brief (NCHS).[37] The mortality rate for California excluding Medicare and Medi-Cal Populations was estimated using the NCHS issue brief along with census data and California market share estimates published by CHBRP (as noted in footnote 2).

Substituting the above values for each variable in the final formula, HAO obtained:

N = Number of Lives that may be Saved in 2015 = 26.

Estimated Lives Saved		
X	California Under 65 Population, excluding Medi-Cal	24,710,019
p	Proportion of **X** with health coverage	88.5%
q	Proportion of **p*X** which is subject to regulation	9.8%
r	In-network participation %, pre-regulation	87.2%
s	In-network participation %, post-regulation	89.8%
α	Odds ratio, uninsured mort. / insured mortality	1.4
β	Odds ratio of out-of-network mort. / in-network mort.	1.3
ω	Mortality rate	0.175%
$\omega_{i(pre)}$	Insured mortality rate	0.167%
ω_{u}	Uninsured mortality rate	0.234%
ω_{ii}	Insured "in-network" mortality	0.161%
ω_{io}	Insured "out-of-network" mortality	0.209%
$\omega_{i(pre)}$	Insured mortality rate, pre-regulation	0.167%
$\omega_{i(post)}$	Insured mortality rate, post-regulation	0.166%
N	**Lives Saved**	**26**

9) Appendix B: Further detail regarding bankruptcy impact calculation

The potential consumer financial impact of delay in implementing the proposed regulation was adjusted by the following factors.

First, not everyone has health insurance. There are still many people without coverage, notwithstanding the advent of the requirements of the Affordable Care Act. The MBUS study found that only 60.3% of bankruptcy filers had private medical insurance, which means an

[37] Death in the United States, 2010. Miniño AM, Murphy SL. National Center for Health Statistics data brief, no99. Hyattsville, MD: 2012.

estimated 47,000 filings for 2013 (77,958 x 60.3%= 47,009) could be attributed to those with private insurance. Additionally, the Department's analysis involved several other assumptions: (1) about 9.8% of those with private insurance are in CDI-regulated plans that would be affected by the proposed regulation; (2) the extension of coverage in 2014 and 2015 to the previously uninsured will lower bankruptcy rates by about 5% from 2013 levels; (3) the impact of the regulation due to the share of bankruptcies among individual and small-group policyholders is a reduction of about 10%; and (4) those with outstanding medical debt would file for bankruptcy at the same rate as they do currently. These combined impacts imply about 3,900 bankruptcy filings that would potentially be affected by the proposed regulation (47,009 x 9.8% x 95% x 90% = 3,939 (see Table 1)).

The potential magnitude of the impact of the proposed regulation also involves additional factors. First, out-of-pocket costs are typically higher for the uninsured than for those with private insurance. While the average out-of-pocket medical cost cited by the MBUS study was $17,943 in 2007, it was $17,749 for the privately-insured, and $26,971 for the uninsured. When adjusting the 2007 average medical cost of $17,749 for the privately-insured for medical care inflation, the value in 2013 is estimated to be $21,494. Multiplying the estimate of costs by the estimated number of medical bankruptcies results in a projected impact of $84.7 million (3,939 x $21,494). The $84.7 million is the 2013 total cost of bankruptcies due to large medical bills in CDI regulated markets. This figure was a starting point the Department's further actuarial analysis, while recognizing that not all of the 3,900 households would be equally affected by the proposed regulations.

10) CONTACT PERSONS

Bruce Hinze
Attorney IV / Senior Health Policy Attorney
Health Policy & Reform Branch
California Department of Insurance
45 Fremont Street, 24th Floor
San Francisco, CA 94105
(415) 538-4390
Bruce.Hinze@insurance.ca.gov

Alternate contact person
Diane Pinney
Legal Assistant, Government Law Bureau
Legal Division
California Department of Insurance
300 Capitol Mall, 17th Floor
Sacramento, CA 95184
(916) 492-3456
Diane.Pinney@insurance.ca.gov

-0-